MENTAL HYGIENE

VOL. XIX OCTOBER, 1935 No. 4

DIRECTING THE ACTIVITIES OF THE CLASSROOM TOWARD THE MENTAL-HEALTH OBJECTIVE*

LAWRENCE A. AVERILL, PH.D.

Head of the Department of Psychology, State Teachers College, Worcester, Massachusetts

EVERY human institution of the present day is proceeding on the basis of a widely accepted conviction that the second quarter of the twentieth century marks the end of one age and the beginning of another. In no department of our social structure—strange to say—has this consciousness been slower to register itself than in our public-school system. Despite the fact that we are hearing more or less insistently from many quarters the cry that the curricula of the schools must be radically revised, and notwithstanding the manifold attempts to bring the offerings of the schools into a more realistic and vital relationship with the life for which allegedly they are preparing their pupils, the rank and file of the schoolmen of to-day are still thinking in terms of an obsolescent social age. At a time when the best thought and leadership in the field of education ought to be turned upon the gigantic task of redirecting and readjusting the educational means and purposes, this thought and this leadership have been compelled, during these years of industrial and financial stringency, to devote their principal energies to the maintenance of the old *status quo*.

*An address delivered before a joint meeting of the National Education Association, Department of Supervisors and Directors of Instruction, and The National Committee for Mental Hygiene, Atlantic City, February 26, 1935.

"The schools must not be permitted to suffer!" has been the slogan by which the schoolmen have striven to impress upon the minds of their constituents the supreme importance of bringing our educational machine through a prolonged period of depression without notable impairment of its efficiency.

No one would have the temerity to minimize the importance of this task, and the educational leadership is to be congratulated on the success with which it has kept the schools open and operating. It is a matter of no small gratification that the taxpayers, burdened far beyond the conventional standard of taxation in the United States, have complained little in the main at the moneys paid into the educational channels. As a nation we are proud of our schools, and do not propose to suffer them to be handicapped in their work by the adoption of any niggardly policy of retrenchment—at least, not until our financial problems become far more acute than they have during these last five years.

But the preservation of the *status quo* of the schools—essential as it is for the continuity of that basal institution which we are agreed education is and must forever continue to be—is after all but a passive, a defensive gesture. It is rather an attempt to consolidate positions and hold the line from breaking than it is to advance into new terrain and achieve new objectives in the onward march of a new age and the achievement of new social objectives. It is the purpose of this paper to suggest certain educational readjustments that are vitally in need of being brought about, in the interest of millions of children and adolescents in our lower and secondary schools. These readjustments arise fundamentally out of the new points of view that mental hygiene is impressing upon a few of the leaders in the field of education, and that will have to come to be much more widely adopted by the rank and file of our schoolmen if these institutions are not to remain nineteenth century in outlook and purpose in the midst of a twentieth-century scene.

First of all, the curricula of our schools are, notwithstanding widespread revisional projects, still utterly inadequate to equip the rising generation with the knowledge, the mental attitudes, and the character controls that participative and aggressive citizenship in the American democracy of to-day—

and, in greater measure, of to-morrow—makes imperative. In the social subjects, for example, to mention but one group, we are still in too many educational communities dawdling with battles and campaigns and dates and boundaries and locations and with a brand of detached civics *in vacuo,* isolated and insulated in large measure from the exigencies and the needs of vital and intelligent citizenship in a world that has, in the short space of a quarter of a century, shrunken to the point where it impinges on our very doorsteps. Living in a world in which conflicting cross-currents tug at us from every side, we are content, in great numbers of places, to train our children for living in a world that has forever passed away. This observation is meant in no sense to disparage the newer courses in the social subjects that are being developed experimentally in certain quarters; rather, it is to point out that the newer objectives are still unaccepted and their need even unperceived in many a school system which has not kept up with developments in these subjects. We are apt to talk glibly of training our youth for citizenship; let us take care that it be not an anæmic sort of pseudo-citizenship that closes its eyes to social weaknesses and shortcomings in our communities.

If Americans in considerable numbers to-day shrug their shoulders at graft and dishonesty; if they condone jingoism and play to the galleries; if they countenance the ways of the demagogue and the propagandist; if they tolerate the racketeer and extortionist; if they permit the continuance of the slums and the underworld; if they refuse to take their place with other nations in the rational planning of world affairs; if they draw about themselves smugly and circumspectly the cloak of nationalism and self-sufficiency; if they harbor prejudice and intolerance—I say, if Americans to-day do these things and maintain these mind sets, it is because of no other circumstance than the fact that the schools of yesterday failed to educate for intelligent and participative citizenship. Content with building in academic knowledge, with developing scholastic skills and abilities, they succeeded merely in providing a generation economically ignorant and socially impotent. In a complex social age, which is changing more rapidly than probably has been true of any previous age,

where shall our vaunted democracy—nay, our very civilization itself—end up if we dare to train to-morrow's citizens according to the same innocuous formulæ by which those now in the saddle of affairs were trained?

If mental-hygienists are showing us one thing more significant than any other, it is that what a boy learns in school is of really little present importance to him, and of still less permanent importance to him after his school life is over and he finds himself catapulted into a social and economic and political *milieu* that requires of him grotesquely different kinds of reaction from those that he has been habituated by his schoolroom career to make. In a sense far more real than most of us have yet even envisaged, the adequacy of the educational service of to-morrow—or, more precisely, of to-day for to-morrow—must be judged in terms of its success in orienting the mental attitudes and feelings of boys and girls. If the typical school achievement in this country is completion of the seventh grade or thereabouts, the conclusion is patent that unless the child, while still in the lower school, can have his sympathies cultivated and his attitudes at least basally shaped in broad patterns along the lines of desirable human progress and adventure, the chances of his ever becoming a citizen competent to play an aggressive rôle in molding the future of the nation are disconcertingly and alarmingly slight. We have become so accustomed to the experience of graft, of jingoism, of demagoguery, of crime and thuggery, of national smugness and self-sufficiency, of prejudice and intolerance, of snap judgment or no judgment at all, that it is somewhat difficult for the rank and file of us to envisage a way of education that might be expected to reduce the grip of all these infantilisms upon the body politic.

But the case for the future is not so hopeless as it might seem. Given a tangible educational philosophy to designate the goals and purposes of education; a complement of textbooks, source books, and materials to exemplify them; and a teaching body competent to clothe them with life and reality, there ought to be no question regarding the outcome. The educational leadership in those countries of Europe that are under dictatorships has no difficulty in training up a generation of youth consecrated zealously to the ideals and prin-

ciples of the particular oligarchy under which they are placed. When I was a student in Germany in pre-war days, I noted that Kaiserism had no difficulty in building into German youth an allegiance to its principles so implicit and profound that it amazed the world between 1914 and 1918. I cite these pedagogic outcomes of autocratic forms of government not in support of autocracies—whether of the dictator or the proletariat, both of which I abhor—but rather as an evidence of the fact that it is distinctly possible for a people to cast its rising generation in whatever mold it pleases. The difficulty with us is that we do not feel very vitally about the mold through which we are sluicing childhood and youth. Possibly that lack of conscious and fixed purpose in the schools is an inevitable concomitant of democracy, where the trend of the educative influence reflects obviously no dominant propaganda and no long-range aim.

These three essentials to purposeful education in a democracy—a pervading educational philosophy, a complement of appropriate teaching materials, and a properly qualified teaching personnel—merit some consideration.

In the matter of the philosophy of education, one fact stands out strikingly in the present American scene: the educational leadership needs, more than anything else I can think of, to sit for a time at the feet of the mental-hygienists and learn of them the tremendous rôle played in our lives by mental attitudes, and next to realize that the outstanding attitudes the rising generation is in danger of taking from its classroom experiences are ennui over set tasks, boredom over meaningless content, prejudice and narrow-mindedness, content with what is, *laissez faire,* failure or discouragement, intellectual satiety, distaste for reflective thinking and reasoning, and a considerable number of other paralyzing mind sets that cannot but be presumed to carry over distressingly into subsequent family, community, economic, and political life.

This is not a very flattering picture, but unfortunately it is a far truer one in some of our educational communities than is the ideal picture one would like to draw. The prevention of these undesirable attitudes which are so likely to fasten themselves upon children in the schoolrooms of the

land lies, first, in recognizing them as pernicious; second, in a far-reaching agreement among schoolmen as to what are the lasting values worth setting up as educational goals; and third, the combining of these goals into a revolutionary school program that will change over the traditional educational provender from a starvation diet of facts, events, and static conditions to a nutritive one of forces, social trends, and dynamic processes. Toward the former, live young learners can be expected to develop only the conventionally negative attitudes of the traditional schoolroom; toward the latter, these same learners can hardly escape forming desirably positive and aggressive attitudes.

Who can predict the heights that our American education might attain if our schools cared to build into the personality fiber of their young charges an attitude of sympathy and appreciation of their world neighbors, for example, in place of a semi-contempt, or at best a thinly veiled, passive tolerance? An attitude favorable to international coöperation and responsibility, in place of a narrow and isolated self-sufficiency? An attitude of intolerance of graft, of crime, of "spiritual wickedness in high places," in place of one either of indifference, condonation, or hopelessness with regard to these evils? An attitude of respect for truth, fair play, social justice, and the open mind, instead of shady ideals and the closed mind? An attitude of distrust toward the jingoist, the demagogue, the propagandist, and of high regard for the fruits of the intellect, of reason, and of the experimental approach to knowledge? If the present adult generation of citizens had been disciplined in these mental attitudes throughout its early schoolroom contacts, with the social subjects taught rather as indicative of a dynamic civilization than of static episodes in a dead past and a lifeless present, it would not to-day represent so nearly a rudderless ship tossing about in the social vortices and whirlpools, without fixed chart or compass.

In the new age, it will not do to make the blunders that were made by a past generation of schoolmen. The risk is too great. The forces unleashed in the world are too powerful and bewildering to permit of jingoistic panaceas. This democracy—which represents, theoretically at least, the com-

bined suffrage of all the people—cannot endure as a hit-or-miss proposition. It cannot be preserved by the blind, or the passionate, or the ignorant, or the smug. It cannot be brought through the difficult days on which it has fallen except through a radical transformation of the points of view and the mental attitudes of its citizens, which will permit them to envisage the whole matter of human evolution with such foresight, reason, and aggressiveness as have been rarely exemplified in our history. And the bringing about of this metamorphosis in the citizens of the Republic from detached indifference to strong and intimate social and economic concern and participation is in a very peculiar sense placed in the hands of the educational leadership of to-day and to-morrow. It is high time this educational leadership devoted less attention and energy, for example, to self-expression in education, and to its obsession over tests and measures—to mention but one or two of the points of considerable emphasis in our modern set-up—and much more attention and energy to the building of a course of study that might be expected to turn out a generation of people capable of rational self-control and intelligent self-government.

This leads to the second essential in purposeful education for the modern age and for citizenship in a democracy—namely, appropriate teaching aids, and notably textbooks and source materials. Time precludes any extended discussion of this essential, for I am anxious to dwell at some length upon the third. Suffice it merely to point out that we have as yet only a few textbooks in any of the social subjects that are adequate. All except our most recent histories are still preoccupied with records of military campaigns, of detailed chronologies, of misplaced emphases and distorted perspectives. Instead of being introduced to a nation and a world in process of evolution, of becoming, the pupil is presented to a civilization and a culture that are fixed, complete, and mummified. All but the newest geographies are committed to the portrayal of regions, of type factors, of physical and physiographic features, and almost completely ignore the development of a concept of man as a universal creature, driven everywhere by the same urges, impelled everywhere by the

same desires for room, for opportunity, for freedom, for a place in the sun. Instead of presenting a nation and a world of human beings activated by common purposes and common ideals, too many of the texts present men in isolation, hemmed in by geographic barriers from other men, and disconnected in human and social traits and aspirations from the rest of the world. Our newer textbooks in citizenship have made a modest beginning, and the latest books in economic geography and universal history are aiding likewise in placing the emphasis in the social studies where it must ultimately come to be—namely, upon *man—universal man.*

As these improved types of source books multiply, one can foresee the coming of a new day in our schoolrooms, wherein those who are to become the voters and the workers and the leaders in the manifold human activities of the morrow may have builded into the fiber of their beings attitudes and convictions of mind that will go far toward salvaging our civilization from the social and political and economic muddle into which an untaught—one should better say a mistaught—generation has brought it.

It has taken us altogether too long to emancipate the lower school—the common school of the masses—from the domination of a collegiate philosophy which stresses the laying of the elementary foundations of a liberal-arts culture for millions of future citizens who will never pass on to the secondary school, much less to the college. Until we have courses of study and textbooks that shift the emphasis in the education of our people from cultural formalism to social and human adequacy, we shall continue the anomaly of training in the schools for a way of life that is utterly unsuited to the potential and practical needs of the masses of the people. I would not like to be misunderstood, and to be interpreted as raising a question as to the value of culture and refinement in human life. Heaven knows, we have far too little of both! What I am pointing out, however, is the unwisdom of neglecting to equip the next generation with training for socially adequate living in the broadest sense of the term. Surely culture and refinement are not incompatible with such a goal for education.

The third essential in purposeful education for the modern

age—a greatly improved quality of teaching personnel—is of even more importance than the other two, if those human attitudes and mind sets which we believe, with the mental-hygienists, to be indispensable to adequate personal and social adjustment are to be achieved in the oncoming generation. The educational leadership of America is partially closing its eyes to one of the greatest opportunities to raise the standards and qualifications of the teachers in this country that has been presented in two generations. The industrial stringency of these past five years would have been to a degree fortunate if it could have resulted in the instigation of a more rigorous and planned policy of selection of candidates for the teaching profession. With tremendous increase in the numbers of applicants, and with the supply already well in excess of the demand, the opportunities for raising the bars far higher than they have ever been were almost providential. But what have we seen? In the words of Assistant Commissioner Cooper, of New York State, teaching remains "one of the few professions which continue to follow the open-door policy." Many of our leading states and educational communities have thrown open their schoolrooms to meagerly equipped teachers, with little training, or with training that may have qualified them years ago, but no longer does; teachers who are now, in the words of State Supervisor Bunce, of New Jersey, "incompetents—floating around, looking for positions." Mr. Bunce estimates that there are in Pennsylvania and New Jersey combined 12,700 unemployed people who, though improperly prepared, are legally certifiable to teach, and that about 40 per cent of them are not properly qualified.

Taking the country by and large, the standards for admission into the teaching profession are unbelievably low, it being still shamefully the fact that one year of professional training beyond the high school is the typical status of the teachers of this nation. Where would the great profession of medicine be if bungling practitioners were thus turned loose upon a defenseless constituency? During a decade that has seen the standards for admission into the medical schools consistently raised, we have been seeing in too many states a bar removed from the gateway into the schoolroom. It is refreshing

indeed to hear that a few states are adding to rather than removing their bars, and that there is no alarming oversupply in this country of properly trained teachers.

But we must go much further than this and not rest satisfied until we have identified the most promising young men and young women in our secondary schools, and made selections from them, and from them only, for annual recruits to the teaching army. I am free to admit that we do not yet know how to select intelligently those young persons who have good teaching promise. I have been engineering in my own state of Massachusetts for the past four or five years an investigation looking toward the ascertainment and measurement of teaching aptitudes, and must confess myself unable to predicate at this time the indispensable traits and aptitudes of the potentially successful teacher. Certainly there is an extensive "twilight zone" in which it is thus far imprudent to attempt to say what the prospects are for creditable teaching on the part of those candidates whose abilities and personalities fall within it. But it is equally certain that there is a broad region of personality and of intelligence outside this penumbra, and that there is a reasonable expectation of creditable schoolroom service for all who fall within its borders.

It appears to be more and more the experience of superintendents that candidates for teaching positions who have been good students of the conventional and traditional subjects in the secondary school, and who have stable characters and personalities and a determination to succeed, are extremely likely to turn out to be excellent teachers. There are enough young people of this type graduating from our high schools every year to keep the ranks of the teaching order constantly filled. Instead of solicitude for enlisting them in teacher-training, however, we waste our time and jeopardize the future of the schools by admitting into our teachers' colleges and normal schools any and all who apply. At least, if conditions are not quite as discouraging as this in all parts of the country, they approach it in many of them.

When shall we have a strong conviction on the part of schoolmen that the level of our national standards, our ideals, our purposes and convictions can rise no higher than their

source in the schoolrooms of the land? If we are content to leave the shaping of our mental attitudes, our sympathies, our emotions, our tolerances, and our sentiments to any save those guides of young minds who are chosen from among us for the fineness of their own characters and the sincerity of their own devotion to the great cause of human betterment, we shall but be defeating the loftiest purposes of true democracy. No matter how high may be the educational philosophy that activates the schoolmen, no matter how enlightened the teaching materials may be, nor how well adapted they may be to the fostering of wise and needful mental attitudes in the learners, unless those who direct the intimate building in of these mind sets are competent in their interpretation of them, the social and aggressive purposes of education can never be achieved. Are we to build for open-mindedness and suspension of judgment until the facts are all in? Let us look to the teachers! Are we to build for world neighborliness and understanding? Let us look to the teachers! Are we to build for the continuation beyond the school life of intellectual curiosities and social culture? Let us look to the teachers! Are we to build for integrity, the rule of reason, the reflective mind? Let us look to the teachers! Are we to build for social justice, human welfare, economic fairness, political integrity? Let us look to the teachers! It is they who in a very peculiar sense are shapers and definers of the world to-morrow.

For after all the facts they teach their young charges will be soon forgotten. It is only through the skill and the control with which they teach their pupils to use their minds, and the integrity with which they teach them to shape their attitudes and direct their emotions, that the teachers of a nation have any lasting claim to educational and social immortality. Certainly those who do not or cannot understand the social implications of an evolving and progressing democracy; or who have not enough faith in the common man to believe that he can achieve far better things for himself than have yet appeared; or who are not possessed of a world view that encompasses the human scene in some sort of rational perspective; or whose attitudes toward problems of the social weal are myopic and provincial—these are hardly worthy of

the high trust laid upon them. And in a more restricted and personal sense, those who are themselves lacking in culture and refinement, in positive traits of character and personality, and in the ambition to devote themselves with conviction to this highest of all forms of social service, belong anywhere except in the schoolrooms of this nation.

Most of what has been said up to this point has been with reference to the lower school. For the remainder of this paper I should like you to bear in mind with me the pupils and the teachers in our secondary schools. In 1900, approximately 10 per cent of the total population of high-school age actually went to high school. To-day, more than 50 per cent of it goes to high school; moreover, twice as many pupils are being held to the fourth and final year as was the case in 1915. It appears that less and less does the secondary-school population represent a selected and superior group. Thorndike estimates that 95 per cent of the high-school pupils of 1890 were above average in mentality. An investigation in 1918 indicated that this percentage had dropped to 83 per cent, and while no comprehensive research adequate to base a satisfactory estimate upon is at hand to-day, it is not improbable that from one-third to one-half of all those enrolled to-day in our American high schools are below or no better than average.

To meet the needs of such a polyglot mass of seekers after a high-school education, the schools themselves are being hard put to it to revamp their offerings. Indeed, less than one-half of upwards of 8,000 secondary schools reporting to the U. S. Office of Education in 1932 were making any provisions whatever for adapting their junior- and senior-high-school programs to individual pupil aptitudes, and the investigator exclaims: "The facts and theories concerning individual differences, which have filled library shelves to overflowing during the past quarter of a century, are still reposing on library shelves, or echoing through the lecture halls of schools of education, much more generally than they are incorporated in the practice of secondary schools." The rest of the 8,000-odd schools are doing a little something to salvage this flotsam and jetsam of adolescents that swirls through them by providing remedial classes; "adjustment" rooms; segregation of the slower pupils, especially in such fundamental subjects

as English and mathematics; homogeneous grouping; and so on. An inevitable outcome of all this besieging of the secondary school on the part of the adolescent group is bound to be either the permanent lowering of the standards of the schools, or the provision of a wholly new type of secondary institution adapted to the potentialities of the individual pupils.

For the sound mental health of hordes of undifferentiated adolescents, exposed thus to the traditional academic high-school provender, for which their assimilative systems are ill-suited, I entertain very grave apprehension. Can one blame them for the aimlessness of purpose, the attitudes of indecision and detachment that grow upon numberless young people for whom the educational machine, because it is a mass machine, fails ignominiously to build either skills and factual knowledge, or the habits and attitudes needful for wise and satisfying living in the community, after the school experience is ended? Only the barest beginnings of clinical and psychological study of high-school pupils has been undertaken. Personnel and vocational analyses have been only begun; hence the foundations of happy and satisfying occupational participations remain largely unlaid.

It is easy, of course, to place the blame for these dubious mental attitudes and these social and economic failures-in-embryo, so commonly observed in the high-school group, on the doorstep of the school itself. It is easy to point out that schools are overcrowded and their patrons undifferentiated; that their curricula are anachronistic; that teachers and materials are inadequate to challenge the best efforts of the learners and to inspire in them desirable social attitudes and ideals; that even the honored doctrine of interest has not been completely innocuous in its effects upon the present adult generation, for whom it may well have been but a step from the enjoyment of an "easy" school experience to the seeking of an "easy" and ambitionless life experience.

But schools and teachers are not entirely to blame. Beyond the environment of the school, one must admit that our emotions universally to-day are fed on tinder, and that by contrast with the sophistication and the social froth of the community,

the schoolroom experience may indeed appear drab and uninspiring to all save the more eager-minded and stable intellectuals. These wider, non-school stimuli cannot but be expected to exert a disturbing influence over the formation in young persons of such fundamental human traits as sincerity, ambition, determination, industry, and the like, all of which we no doubt are agreed the total experience of young people ought to encourage.

I should like here to introduce one or two brief case studies of adolescents in our great American secondary-school system. Reading between the lines, as it were, one can readily detect the disturbing effects of the general community influence upon the shaping personalities and attitudes of the school group.

Loring, sixteen years of age, would to-day be a senior in high school if he could have been content to go through with his course. Throughout the two first years, he idled away most of his time, insisting that his teachers were old fogies, and that what they taught was useless and monotonous. When his sophomore year was ended, he announced to his parents that he was not going back to school in the fall. School was, in his expressive language, "the bunk," and nearly drove him frantic, it was so slow. He proposed to devote himself to his saxophone and develop a first-rate jazz orchestra that would wake up the world! There would be no interruptions from protesting parents and mossbacked teachers!

When fall came around, however, Loring went back to school. If his scholastic standing, despite his obviously good intellect, had been poor before, it now grew rapidly impossible. Before the year was half over, he informed his parents a second time that he was through; that he had no interest in the things he was studying; that his teachers were a "bunch of ignoramuses"; and that he felt constantly cramped and crushed by the monotonous routine of school work. His parents remonstrated, but finding the boy to be deeply in earnest, they allowed him to discontinue his course. No job offering, Loring has since striven hard to fill his life with jazz, "movies," and dancing.

Fan, fifteen years of age, is a somewhat overdeveloped girl, of good intelligence, but decidedly poor conduct. Taking her cue from her physical robustness, she affects a type of dress several years too old for her, assumes a supercilious attitude toward her teachers, and flirts constantly with the boys of her class. As might be supposed, she gets on poorly with her school work, is troublesome to her teachers, and is hypercritical of everything and everybody. Her standards and ideals are the standards and ideals of the silver screen and the public dance hall, to which latter her overdevelopment gives her unquestioned entrée. She is loud, boisterous, and extremely thoughtless and impolite. She is unable to settle down quietly at anything, but must be continually darting about from one activity to another. She is the despair of her

teachers, though usually acclaimed by her mates, and she is always the center and soul of all social and extra-school occasions. Her conduct is barely respectable, and her interests are limited to dancing, the "movies," and dashing about in wild motor parties. Her mild-mannered and scandalized parents profess themselves helpless in the situation.

Still, when we have made due admission that the restlessness and aimlessness of modern community and social life are reflected inevitably in the attitudes and the performance of the schoolroom, we should not lose sight of the fact that it is the responsibility of the schoolmen to look to their schools rather than to point an accusing finger at parenthood or at community shortcomings as accountable for the fostering and promotion of unsound mental hygiene in the high-school group. Let me quote the following bit of writing by a high-school student, which Dr. J. R. Shannon includes in an illuminating monograph, entitled: *Personal and Social Traits Requisite for High-Grade Teaching in Secondary Schools.*[1] Dr. Shannon explains: "This is a unified picture of every-day happenings. All of the incidents are genuine, but did not occur on one day. . . . I know the picture is not overdrawn."

BEAUTIFUL ENGLISH

Time: 11:13 a.m., any school day
Place: Room 6, ———— H. S.

Seniors and most of the juniors wait expectantly for Miss ————, the English teacher. Enter Miss ———— with English book in one hand and class record book in the other. Comes to front of room and scans record book. Speaks slowly and loudly, with rising inflection on certain words.

Miss ————: It strikes me that some of you will have to begin studying. Do you realize that some of you haven't had passing grades this semester at all? Now, to-day I'm not going to have any foolishness whatever! Now, if any of you start anything, you can just get right out of here. I've had enough of this foolishness! I'm getting tired of it. If you think you can come to this class and do as you please, you are badly mistaken. I won't stand it. And the first one of you whom I catch will go right out of here, and he won't go alone, either, I'm getting disgusted!!!!

(*Snickers from students; a few hand claps.*)

Miss ————: Now I believe we were discussing Longfellow. Howard, tell me all you know about Henry Wadsworth Longfellow.

Howard (shortly): Don't like to talk about the dead.

Students: Har! Har! Har! Chuckle, chuckle, chuckle.

Miss ————: Howard, one more bright remark like than and— (*Howard grins.*) I've had enough of it. There are many reasons why

[1] Terre Haute, Ind.: State Normal Press, 1928.

we should study Longfellow. He is, primarily, the poet of the whole people, the most widely known—

Junior: Teacher, teacher, teacher. (*Waves hand hysterically.*) May I speak to Algernon?

Miss ————: No! YOU GET RIGHT TO WORK.

Junior: Aw, please, teacher. (*Gets up and starts to speak to Algernon.*)

Miss ————: You take your seat, right this minute.

Junior: Where'll I take it to?

(*Much laughter and confusion for two minutes, during which Miss ———— and smart Junior exchange remarks. Finally quiet again.*)

Miss ————: Now, as I was saying, Longfellow is the most widely known and loved of all American poets. He—

(*Enter superintendent. Quiet prevails.*)

Miss ————: Longfellow's first book of poems, *Voices of the Night,* came at the beginning of the turmoil that led to the Civil War.

(*Gives a long speech about Longfellow. Every one orderly, and all answer questions satisfactorily. Exit superintendent. Confusion prevails. Ralph waves his hand in the air.*)

Miss ————: Now what do you want, Ralph?

Ralph: Hey, Miss ————, can I go home?

Miss ————: What for? Why, the idea. I'll send you home in a minute. What do you want to go home for?

Ralph: Wanta see what they got for dinner.

Miss ———— (smiling): Now, Ralph! If you have a satisfactory reason for wishing to go home, write it on a piece of paper and give it to me. You know better than to talk that way!

(*Ralph writes on a piece of paper and gives it to her. She laughs.*)

Senior: Aw, let's study English!

Miss ————: I do not think, Ralph, that is a sufficient reason for your wanting to go home. Please return to your seat.

(*Ralph remains where he is, coaxing and making remarks. Miss ———— argues and continues bantering with him. Finally he sits down. Of course no one studies or recites while this is going on. And so on until 11:53. The class is over and Miss ———— remains in the room until class is to be excused. Cries of "When do we eat?" and "We want our beans!" and "Let's chow!" etc., etc., are heard all over the room until dismissal.*)

The above playlet was avowedly designed to depict a high-school class presided over by a "poor" teacher. How numerous these "poor" teachers are in our schools, perhaps it is just as well that we do not know. There is not a superintendent here, probably, who would countenance the claim that they are in the majority. On the other hand, none would argue that they do not exist, and in distressingly large numbers in our secondary schools. No wonder that Dr. Frank E. Spaulding, of Yale University, opines that high-school

education is becoming less adequate because discipline is giving way to dilettantism. Surely, there is little in the sort of classroom situation I have just quoted to appeal to any save the more clownish and irresponsible of high-school pupils. In such an atmosphere, young persons learn nothing of lasting significance, but are certain to form habits and mental attitudes the reverse of healthful and desirable. In a setting where they ought to be making some headway at least toward the building of real character, they are instead having created within their nascent personalities limiting and destructive attitudes that society can ill afford to maintain high schools and employ teachers to create.

I should like to conclude by quoting one or two advance sheets from a forthcoming volume in the psychology of adolescence, and to close with an additional brief case study or two, indicative of teaching malpractice in the secondary school.

The inadequate teacher of adolescent pupils is not difficult to paint and characterize. She exists in multifarious forms, all of them about equally deleterious to the welfare and the best interests of her pupils. From the standpoint of character and personality, she may offend by having strong likes and dislikes, strong prejudices and preferences. She may be either harsh and unsympathetic with youth, or she may be easy-going and an "easy-mark" for their dilettantism. She may be impatient and quick-tempered, unable to comprehend the vagaries and contradictions of the adolescent age. She may be helpless whenever any disciplinary situation, however slight and inconsequential it may be, chances to arise, taking refuge in a barrage of "wisecracks," or of helpless reproaches and cautions, either of which tactics will but aggravate the situation and make it ten times worse. Reasonably a master in her field—so we may hope—she may err in vouchsafing too little explanation of matters that are simple enough to her, but that present mountainous difficulties to her pupils. She may resort to sarcasm in order to sting them into ambitious conformity, or to shaming them in order to prod their scattered wits into vigorous action. She may inspire dread or actual fear, by reason of her brusqueness, her impatience, or her testy nature. She may be too weak in

her own knowledge of subject matter to inspire respect or to stimulate the ambition of her class. She may be so out of step with youth that she fails to win their sympathy and confidence. She may be forbidding in personality, crabbed in disposition, and temperamentally or by age or experience unsuited for the rôle of teacher and guide of the adolescent group.

From the strictly pedagogic angle, she may be unable to teach with illumination. Her experience may have been limited to second-hand contacts with the things she teaches, so that she cannot vivify her subject with the glow of life and actuality. She may have developed a hackneyed, unprogressive style and method of instruction which cannot hold the eager and roving interest of her young patrons. She may have been a reader of books rather than a student of life and processes, and so have developed a pedantry that stifles and destroys the spirit of true learning. Her interpretation of the learning process may be that of a memoriter, phonographic procedure, utterly divorced from the actualities of vivid thought and intellectual analysis. She may be so limited in her breadth of outlook and experience that she cannot illume her teaching with the richness and variety it ought to have if it is to be made enticing and stimulative to alert young persons. The total influence of her classroom upon them may be little more than what would be offered by a shelf of musty volumes or a museum of catalogued relics of the past.

The three closing case studies are typical of the dubious mental hygiene sponsored by high-school teachers whose shortcomings are included in the foregoing analysis.

> **Eddie, a freshman in high school, was having a difficult time with his algebra. He was doing well enough in his other studies, but was getting very much discouraged over algebra. Since Eddie's marks in arithmetic in the elementary school had always been good, his parents were much concerned over his poor showing in the subject in the secondary school. One evening, when Eddie was having a particularly harassing time with his home work, his father succeeded in getting at the bottom of his difficulty.**
>
> **"Just what is the matter, Eddie?" he asked. "Don't you understand the method in these new examples?"**
>
> **"No," admitted Eddie. "I've read the explanation through and through, but I can't seem to make much out of it. I get mixed up trying to understand it."**

"But, Eddie, didn't Mr. W——— show you how to do them?"

Eddie looked up at his father.

"Oh, he never does!" he exclaimed. "Most of the fellows copy their examples every day from somebody who happens to have them done. We never ask old ——— to explain any more. He either frowns at us for asking him anything, or else he goes through it so fast nobody can get anything out of what he says!"

Aldie, sixteen years of age, failed her sophomore English course. Miss N———, her teacher, was principally responsible. From the first week in Miss N———'s room, Aldie was miserable, although enjoying her other high-school work and doing well in it. This teacher had no hesitation in flaring out angrily at any of her pupils that they were morons, "dumb-bells," imbeciles, who should never have been graduated from grammar school. Upon Aldie her invectives were hurled as frequently as upon any other. Aldie grew greatly afraid of Miss N———, and when she was called upon, could respond only in a frightened, quavering voice which enraged Miss N——— and prompted her to pour still further abuse upon the girl and upon the class in general.

One afternoon, Aldie lost what spark of respect she may have had left for her teacher. She had stayed up the night before until after midnight, putting the finishing touches upon and copying a theme that was due the next day. Feeling that she had worked desperately hard upon the assignment, and that she had done her level best for Miss N———, Aldie approached the English class next afternoon with a trifle more than her usual confidence.

Miss N——— collected all the themes and proceeded to read aloud from the top one in the pile. Finding a grammatical error, she tossed it aside and began another. Again she found a grammatical error on the first page. In anger she snatched up the entire pack, tore the themes in half, and threw them into the wastebasket, with the stinging remark that fifth-graders, if they had any intelligence at all, could write better themes than those. Aldie was stunned. From that day forward, she detested Miss N———, and refused to do anything for her. The failure she received at the end of the term was inevitable.

Lois, now a high-school senior, dislikes mathematics intensely. Five years ago, when she was in the seventh grade, she had a teacher whom she disliked, and from whom she transferred a dislike to the subject taught. This teacher was a very hasty and quick-tempered woman, well past middle age, possessed of a harsh, loud voice which was very irritating to listen to. Each morning, at the beginning of the arithmetic period, there was a ten-minute oral drill. For Lois, this was always an ordeal, since she has never been able to do oral problems quickly. Whenever an error was made, the teacher reacted with cutting sarcastic remarks about the stupidity of her class. Being of a sensitive nature, Lois took these remarks keenly to heart, and when called upon for a quick answer, was so nervous and panicky that she was almost certain to make a mistake.

Frequently at the end of the arithmetic period, the teacher would suggest that if any of the pupils found trouble in understanding any of the work, they might come to her during study periods and have their

difficulties straightened out. Once—the only time—Lois timidly requested aid on a problem. Her teacher looked at the example, and then glared crossly at Lois, exclaiming that she had no business asking her to explain a problem so simple as this; anybody but a fool could solve it without difficulty! In anguish of spirit, Lois accepted the implication, and never sought aid from her again. Throughout the five years that have followed, the girl has retained an attitude of keen dislike for mathematics.

No inconsiderable advance toward adapting the procedures of the classroom toward mental-hygiene objectives will have been made when the teachers themselves are cognizant of the profound influence that the principles of mental hygiene, when applied in the schoolroom, are bound to exert upon the personalities and the attitudes of boys and girls at every age.

MENTAL RETARDATION AND JUVENILE DELINQUENCY *

ELEANOR T. GLUECK, ED.D.
Research Associate, Special Studies, Institute of Criminal Law, Harvard Law School

LONG before the Binet-Simon tests for the measurement of intelligence came into general use, there was much speculation concerning the relationship of intelligence to delinquency. No conclusions were possible, however, in regard to this very important problem, because the measuring rods necessary for establishing even the crudest of relationships between the factors of intelligence and delinquency were not available. And in the early days of mental testing, before the Binet-Simon scale was sufficiently well standardized and before testers themselves were skilled in its use and could gauge the significance of the test results, the estimates of intelligence in delinquent populations were far from accurate. Thus the studies made in the United States (as summarized by E. H. Sutherland) report during the years 1910–1914 a median finding of 50 per cent of feebleminded-ness among delinquent populations; during the years 1915–1919, 28 per cent; during 1920–1924, 21 per cent; and during 1925–1928, 20 per cent.[1]

Professor Sutherland has carefully compiled all the accessible psychometric studies of delinquents made in the United States between the years 1910 (when the mental tests devised by the Frenchmen Binet and Simon were first introduced into America by Goddard) and 1928—some 350 studies in all. His analysis of these data, which of course includes available studies of the intelligence of the general population,[2] brings him to the conclusion that "this survey has not demonstrated feeblemindedness to be a generally

* Reconstructed and modified from notes of an address delivered before the Conference of Teachers of Mentally Retarded Children held under the auspices of the Massachusetts State Department of Education, January 21–26, 1935. Also delivered before the Annual Meeting of the American Association for the Study of Mental Deficiency, Chicago, April 27, 1935.

[1] See article by E. H. Sutherland, "Mental Deficiency and Crime," in *Social Attitudes*, edited by Kimball Young. New York: Henry Holt and Company, 1931. p. 358.

[2] *Ibid*, p. 362.

important cause of delinquency"[1] and that "the most significant conclusion from this evidence is that the relation of feeblemindedness to delinquency cannot be determined by dealing with it in isolation from other factors. . . . The significance of feeblemindedness apparently can be determined only when studied in relation to a great many other personal and situational factors."[2]

Most of the researches thus far made in this general field have been confined to a simple correlation between intelligence and delinquency, accomplished either by a comparison of the mental scores of delinquents and the general population or by a comparison of the recidivism of offenders of varying degrees of intelligence.[3]

In a few studies rather recently made, two or three other factors have occasionally been considered in relation to intelligence and delinquency, such as similarities and differences in the home environments of delinquents of varying grades of intelligence, in companionships, in types of crime committed.[4]

But in no investigation to date, to my best knowledge, has any comprehensive attempt been made to study many factors in the lives of delinquents—familial, personal, environmental, and the like—in relation to degree of intelligence. The materials about to be presented are an effort in this direction. Other studies will of course have to be made of other samples of delinquents before any final conclusions can be reached about the relationship of intelligence and delinquency.

In a group of 1,000 male juvenile delinquents[5] who appeared before the Boston Juvenile Court during the years 1917–1922, and who were referred to the Judge Baker Foundation for diagnosis and treatment recommendations, it was found that 5.4 per cent were of superior intelligence (I.Q. of 111 and over); 36.2 per cent were normal (I.Q. 91 to 110); 28.2 per cent were dull (I.Q. 81–90); 17.1 per cent

[1] *Ibid*, p. 362.

[2] *Ibid*, p. 373.

[3] *Ibid*, p. 362.

[4] Typical of such studies are "Aspects of Delinquency and Superior Mentality," by Ralph White and Norman Fenton (*Journal of Juvenile Research*, Vol. 15, pp. 101–7, April, 1931) and "Mental Level as a Factor in Crime," by Benjamin Frank (*Journal of Juvenile Research*, Vol. 15, pp. 192–97, July, 1931).

[5] See *One Thousand Juvenile Delinquents*, by Sheldon and Eleanor Glueck. (Volume I, Harvard Law School Survey of Crime and Criminal Justice in Boston.) Cambridge: Harvard University Press, 1934.

were border line (I.Q. 71 to 80); and 13.1 per cent were feebleminded (I.Q. 70 and below).[1]

An unpublished study of the intelligence of 3,638 school children in three Massachusetts cities [2] clearly indicates that there is a considerably higher proportion of children of low intelligence in the delinquent group than in the general population of school children. The findings in the two groups were as follows:

INTELLIGENCE OF JUVENILE DELINQUENTS (GLUECK GROUP)* AND OF MASSACHUSETTS SCHOOL CHILDREN (DEARBORN GROUP)

Intelligence level	*Juvenile delinquents*		*School children*	
	Number	Per cent	Number	Per cent
Normal and supernormal (I.Q. 91 or over)	407	41.6	2,872	79.0
Dull (I.Q. 81–90)	276	28.2	511	14.0
Border line (I.Q. 71–80)	168	17.1	199	5.5
Defective (feebleminded; I.Q. 70 or below)	128	13.1	56	1.5
	979	100.0	3,638	100.0

* In 21 of the 1,000 cases intelligence level was unascertained.

This thesis is further borne out by the intelligence distributions of other delinquent groups [3] and estimates of the intelligence of the general population.[4]

[1] *Ibid*, p. 102.

[2] Made under the supervision of Professor Walter Dearborn of the Psycho-Educational Clinic of Harvard University and used with his permission in the Glueck study (p. 102).

[3] See, for example, the following:

Intelligence level	*500 delinquent women* *	*500 delinquent adult males* †	*Boys of Juvenile Court, Toledo, Ohio* ‡	*Girls of Juvenile Court, Toledo, Ohio* ‡
	Per cent	Per cent	Per cent	Per cent
Normal (including superior)	21.8	33.0	22.5	19.8
Dull	28.0	24.1	29.0	18.0
Border line	16.1	22.3	26.7	29.3
Feebleminded	34.1	20.6	21.8	32.9
	100.0	100.0	100.0	100.0

* From *Five Hundred Delinquent Women*, by Sheldon and Eleanor Glueck. New York: A. Knopf, 1934. p. 192.
† From *Five Hundred Criminal Careers*, by Sheldon and Eleanor Glueck. New York: A. Knopf, 1930. p. 156.
‡ From "Intelligence of 600 Juvenile Delinquents," by W. E. McClure (*Journal of Juvenile Research*, Vol. 17, pp. 35–43, January, 1933). These are the cases that appeared before the Juvenile Court in Toledo, Ohio, between January, 1929, and July, 1931.

For further evidence see *Social Control of the Mentally Deficient*, by Stanley P. Davies (New York: Thomas Y. Crowell Company, 1930), in which (pp. 89–90) the percentages of feebleminded in various peno-correctional institutions are given. The facts are entirely corroborative of the above findings.

[4] See *School Training of Defective Children*, by H. H. Goddard (Yonkers,

Regardless of the slight variation in these estimates and the temporary confusion injected into the discussion by the findings of the Army tests—which reported feeblemindedness present in 24 per cent of those tested and purported to represent a cross section of the general population—there seems to be no question that there is a considerably greater proportion of persons of low intelligence in delinquent than in non-delinquent populations. An explanation sometimes offered for this fact is that delinquents of lower mentality are more apt to be arrested and convicted than those of higher intelligence.[1] Granting that there is justification for this assertion, it at least does not appear to be so in the particular group described, for those of lower and those of higher intelligence had all been previously arrested to an equal extent,[2] at an equally early age,[3] and a similar amount of time had elapsed between the earliest onset of delinquent behavior and the first arrest,[4] and between the earliest onset of delinquent behavior and appearance before the Boston Juvenile Court.[5]

Further evidence that in this group, at least, the delinquents of lower intelligence had not been apprehended any more often than those of higher intelligence is revealed in the fact that of those arrested during a five-year period after the end of "treatment" by the Boston Juvenile Court, the

New York: World Book Company, 1914), in which (pp. 43–44) a study of 2,000 school children indicates that 2 per cent were "so mentally defective as to preclude any possibility of their ever being made normal and able to take care of themselves as adults." See also L. M. Terman, who in *The Measurement of Intelligence* (Boston: Houghton Mifflin Company, 1916) states (pp. 66 and 79) that of 1,000 unselected school children in various schools in the western states, 2.3 per cent had intelligence quotients under 75. Sutherland reports (*op. cit.*, p. 362) that 4.24 per cent of the school children tested in one California county were found to be feebleminded. F. Kuhlman, in "A State Census of Mental Defectives (Minnesota Sfate Board of Control *Quarterly*, Vol. 23, pp. 23–25, 1926) reports 5 per cent of feebleminded in Minnesota; while Dr. S. W. Hamilton in his *Mental Hygiene Survey of Rhode Island* (New York: The National Committee for Mental Hygiene, 1924) reports 8.6 per cent in that state.

[1] See for example, " A Research on the Proportion of Mental Defectives Among Delinquents," by Augusta F. Bronner. (*Journal of Criminal Law and Criminology*, Vol. 5, 1914–15, p. 561.) See also Sutherland, *op. cit.* p. 364.

[2] Unpublished table.

[3] Unpublished table.

[4] Unpublished table.

[5] Unpublished table.

average number of arrests,[1] and also of convictions,[2] was the same. Even were this not so, however, a comparison of the backgrounds and characteristics of this or any other group of delinquents of lower and higher intelligence in sufficient numbers would be revealing of the relationship between intelligence and delinquency, although it would not make possible a determination of the expectancy of delinquency among those of lower intelligence as compared to those of higher intelligence.

Because of the uncertainties in finer gradations of mental levels, it seemed best to divide the 1,000 male juvenile delinquents into two classes—those of higher intelligence (I.Q. of 81 and over) on the one hand and those of lower intelligence (I.Q. of 80 and below) on the other. S. P. Davies very succinctly points out that "all of the intellectually subnormal (morons) are at least potentially feebleminded by reason of the ever-present possibility of social failure."[3] Some may disagree with this twofold classification, but because this is an initial attempt and the series comparatively small on the side of *low intelligence,* the materials were studied on this basis. The edges of the classification may be a bit ragged, but the general trend of difference is nevertheless distinguishable.

In the group under consideration, whose average age was thirteen years, five months (average deviation 1.25) at the time of their appearance before the Boston Juvenile Court, there were 296 boys whose I.Q.'s were 80 and under and 683 whose I.Q.'s were 81 and over. We are concerned to know in what respects these two groups resemble and differ from each other. Such a determination should enable us to arrive at some tentative conclusions about the significance of the factor of intelligence in the pattern of crime-conditioning influences.[4]

Family Background.—First of all, what can we glean from

[1] Unpublished table.

[2] Unpublished table.

[3] *Social Control of the Mentally Deficient,* p. 11.

[4] All the original data herein presented are derived from unpublished tables prepared by the author from the statistical materials that formed the basis of *One Thousand Juvenile Delinquents.*

this material in regard to the extent of the probable biologic inheritance of low intelligence? Regardless of the several possible reasons for mental defectiveness, both innate and acquired,[1] and the difficulty of obtaining such data in a social case history, there is sufficient evidence for the assertion that in at least 73 per cent of the cases of delinquents of lower intelligence, mental defect—the exact grade could not be defined—was present in other siblings of the delinquent or in one or both parents, or in other blood relatives singly or in combination; while in the families of the delinquents of higher intelligence, mental defectiveness—of one grade or another—was found in only 45 per cent of the cases. Since the difficulties of gathering such data were equal in both groups, it seems quite safe to assume that there was a considerably greater inheritance of mental defectiveness in the one group than in the other. For such significance as there may be in it, the fact should be stated that in not so high a proportion of the cases of delinquents of lower intelligence as in those of higher was there a family history (among blood relatives) of other kinds of mental abnormality (disease or marked peculiarity), the percentages being 39.0 and 50.5 respectively.

Who are the families of the young delinquents of lower intelligence? In half the cases the younger parent was under twenty-one at marriage. This of course very generally refers to the mothers, and is somewhat indicative of the extent to which they were prepared to meet the burdens of parenthood. A higher proportion of them than of the parents of the young delinquents of higher intelligence married when they were under sixteen (7.2 per cent as compared to 4.3).

What of the educational equipment of these parents? Three-fifths of them had had no schooling whatsoever, though some could read and write, and only in 1.2 per cent of the cases had one parent even entered high school. There was a considerably higher proportion of illiterates among the parents of young delinquents of lower than among those of higher intelligence (40.7 per cent as compared with 23.9 per

[1] See discussion on this point by Davies, *op. cit.*, Chapter X, *Changing Concepts of Heredity.*

cent) and at the other end of the scale a higher proportion of parents of delinquents of higher intelligence had entered high school (7.5 per cent as compared with 1.2). The low educational status of the parents of delinquents of lower intelligence is further indicated by the nature of their occupations. One-half of the fathers were unskilled workmen (peddlers, teamsters, day laborers, porters, janitors, factory hands); one-third were in skilled trades (plumbers, electricians, bakers, tailors, barbers); 6 per cent were small shopkeepers; and but 1.4 per cent were in clerical occupations. The fathers of delinquents of higher intelligence were to a far less extent unskilled workmen (37.5 per cent as compared with 53.5 per cent); more of them were small shopkeepers (9.7 per cent as compared with 6.3 per cent); more of them were in clerical occupations (4.8 per cent as compared with 1.4); and a slightly higher proportion were in skilled trades (37.8 per cent as compared with 32.1).

These facts already somewhat reflect the differences in the socio-economic status of the families under consideration. Only 15 per cent of the families of the young delinquents of lower intelligence were in comfortable circumstances, while 85 per cent were constantly on the ragged edge of poverty, which means that in the event of illness or unemployment of the breadwinner resort to outside aid became necessary; while among the families of delinquents of higher intelligence fewer were in near-poverty (72.9 per cent as compared with 84.6) and more were in comfortable circumstances (27.1 per cent as compared with 15.4).[1] In two-fifths of the cases of delinquents of both lower and higher intelligence, the mothers worked to provide or supplement the meager income. In 8.1 per cent of the families of the delinquents of lower intelligence, boarders or lodgers were kept, while this was so in only 0.6 per cent of the cases of delinquents of higher intelligence. This of course further reflects the greater economic stress among the families of delinquents of lower intelligence.

[1] For detailed definitions of all terms used throughout this paper, the interested reader is referred to *One Thousand Juvenile Delinquents*, Definitions Index, p. 322 *et seq.*

In the light of their greater poverty, it is entirely consistent, therefore, to find that 90 per cent of the families of the young delinquents of lower intelligence had been making their homes in unsavory neighborhoods, where street gangs were in evidence, where vice and crime were rampant, and where facilities for the constructive use of leisure, though perhaps present, were completely overshadowed by vicious influences; while in the case of the families of delinquents of higher intelligence, who in turn were not to such a degree poverty-stricken, a lesser proportion lived in such unwholesome neighborhoods (83.9 per cent as compared with 90.4). It is further consistent with the picture of economic conditions and the neighborhood settings in which the families of young delinquents of lower intelligence were found to have lived that in over 78 per cent of the cases their homes were overcrowded, dirty, shabbily furnished, and with no physical advantages; while in the case of delinquents of higher intelligence, the extent of such inadequate physical surroundings was considerably less (55.4 per cent as compared with 78.7).

Let us now turn our attention to those factors which reflect the suitability of the home for the wholesome rearing of children. What happened between the four bare walls? What of the size of the families that crowded them, the extent of culture conflicts between native-born children and foreign-born parents, the conjugal relations of the parents, their attitude toward the children, the character of the disciplinary practices to which the youngsters had been exposed, and the pattern of behavior characteristic of these family groups?

The average number of children in the families of the delinquents of lower intelligence was 5.4; while there were fewer children in the families of our delinquents of higher intelligence, only 54.9 per cent having five or more children as compared with 64.8 per cent of the families of our delinquents of lower intelligence.

To this picture of ignorance, poverty, and size of family, we must now add the factor of possible culture conflict between the native-born children of foreign-born parents. In this we see an equal opportunity for clash of cultures

between sons and their parents among the young delinquents of lower and those of higher intelligence, for in some seven-tenths of all the cases the boys were native born and the parents foreign born. It should be added that four-fifths of the boys in both groups were native born.

Before discussing the relationship of the parents of our boys to each other, let us have what evidence presents itself on the attitude of the parents toward the boys. In one-third of the cases, the fathers of the delinquents of lower intelligence were quite indifferent or decidedly hostile to the boys, and in a fifth of the cases the mother's attitude might be so characterized. Delinquents of higher intelligence had the same proportion of fathers who had no feeling of affection for them, but they had a lower proportion of mothers who were devoid of natural love (16.5 as compared with 22.2 per cent). Perhaps parental dissatisfactions in the marital relationship were partly to blame for this degree of indifference and hostility to the sons, for in over a third of the cases (37 per cent) the marriages were unhappy, as evidenced by constant bickerings between the spouses or by actual separation, desertion, or divorce. This parental incompatibility was equally present in both groups of delinquents.

What of the disciplinary practices of these parents? In three-fourths of the cases the fathers of the delinquents of lower intelligence were poor disciplinarians in that they were so overstrict as to inspire fear in the boy or so lenient as to exert no controlling influence on boys who, as will be seen a little later, were to a marked degree easily influenced and suggestible. A lower proportion of the fathers of the young delinquents of higher intelligence were such unsuccessful disciplinarians (66.5 per cent as compared with 75.6). The mothers of the young offenders of lower intelligence were equally ineffectual in controlling them, 77 per cent being poor disciplinarians as compared with 67 per cent of the mothers of delinquents of higher intelligence. The ineffectiveness of these parents in their marital and parental relationships is further evidenced in the fact that in 92 per cent of the families, either one or both parents and/or siblings of the

delinquents of lower intelligence were themselves delinquents. An almost equally high proportion (86 per cent) of the families of the delinquents of higher intelligence contained other members who were themselves antisocial individuals.

The unsuitability of the homes of our young delinquents of both lower and higher mental levels is readily summarized in the statement that in some 43 per cent of all the cases a natural home situation did not exist throughout the childhood of our boys, either because the parents had separated, because one or both had deserted, or because one or both had died, these breaks occurring, in 74 per cent of the cases, before the boy had reached the age of ten. And in those cases in which the homes were not actually broken, 49 per cent were not conducive to the best interests of childhood for other reasons: either the parents were themselves criminalistic, or they were unhappily mated or did not know how to control their children; or the mother worked outside the home, leaving the children unsupervised; or they were grossly neglected in other ways; and so on. Thus in a total of 92 per cent of our cases, the four walls of "home" contained one or more elements that make for the unwholesome rearing of children. And in this respect the delinquents of lower and those of higher intelligence were similarly disadvantaged. The inadequacy of these homes and of the people who constituted the families of our delinquents is further evidenced in the fact that in 87 per cent of the cases, both those of lower and those of higher mentality, social-service agencies of one kind or another—those concerned with problems of relief, family welfare, unemployment, child care, or health—had already been called into operation in an effort to ameliorate somewhat this "kingdom of evils."

Personal History of Delinquents.—So much for a description of the similarities and differences in the familial setting of young delinquents of lower and those of higher mentality. It has already been stated that the average age of the group was thirteen years and five months at the time when they appeared before the Boston Juvenile Court and were in turn referred to the Judge Baker Foundation for diagnosis.

Before looking back over their brief, but already confirmed delinquent careers, let us note the similarities and differences in the way of mental abnormalities other than defectiveness revealed in the clinical examinations of them at the Judge Baker Foundation. In both groups—those of lower and those of higher intelligence—almost the same proportion (13.2 per cent as compared with 14.0) were diagnosed either as psychotics (or cases in which psychosis was strongly suspected), as constitutionally inferior personalities, as epileptics, as peculiar personalities, as post-encephalitics, or as psychoneurotics.[1] But among those of lower intelligence none were diagnosed as unstable adolescents, while 9.9 per cent of those of higher intelligence were so characterized. Almost half (46.9 per cent) of those of lower intelligence, over and above those who had already been included in any one of the above categories, were noted to have marked liabilities of personality—mainly oversuggestibility or emotional instability, and in some cases excessive sensitiveness or oversexuality, cruelty, bullying, or stubbornness in marked degree. A smaller proportion (29.9 per cent) of those of higher intelligence were so characterized. But only half as many of the young delinquents of lower intelligence (8.1 per cent as compared with 16.1) were found to have abnormal ideations (sexual or criminalistic in nature) or crime-causative conflicts (sex, parental) or dissatisfactions.

Clinical examination of these boys, in addition to revealing the differences in their mental make-up, indicated that those of lower intelligence were in somewhat poorer health, 51.2 per cent of them not being well developed physically or having serious chronic conditions or handicaps in contrast to 40.1 per cent of those of higher intelligence.

The boys of both intelligence groups were of an average age of nine years and seven months (average deviation 2.22) when their delinquent tendencies first manifested themselves. In 34 per cent of the cases, they were under nine years old;

[1] The proportions of these conditions differed in the two groups, but as the numbers in each are small, no great significance can be attached to a comparison more detailed than the one given. However, it is stated for what it may be worth that a higher proportion of those of greater intelligence were earmarked psychopaths (7.1 per cent as compared with 2.7).

in 51 per cent, they were nine to twelve years of age; and in 11 per cent, they were thirteen or fourteen. Delinquents of lower and of higher intelligence in equal proportions (64 per cent in each group) had been arrested prior to the commission of the offense that brought them before the Boston Juvenile Court, the first arrest[1] having occurred at equally early ages in the two groups—30 per cent of the boys having been under eleven, 56 per cent between eleven and fourteen years, and 13 per cent fifteen or over.

In only 3.4 per cent of all the cases can it be said that there had been no indicia of delinquency recognizable to the trained observer prior to the arrest that brought the youngster before the Boston Juvenile Court and the Judge Baker Foundation. It is to be noted at this point that in both groups of cases an equal period of time had on the average elapsed between the onset of delinquent behavior and the Boston Juvenile Court-Judge Baker Foundation "treatment" (average three years, three months; average deviation 1.67); so that the pattern of antisociality was of like duration. Such signs of delinquent trends as bunking out, running away from home, truancy, stealing, illicit sex practices, drinking, gambling, habitual lying occurred singly or in combination in 96.6 per cent of the cases among delinquents of both lower and higher intelligence.

This description of the early antisocial conduct of our delinquents of both lower and higher intelligence is entirely in keeping with the finding that 96 per cent of all of them used their leisure hours harmfully—which means that they had unwholesome companions or recreations. However, more of the delinquents of higher intelligence (11.7 per cent as compared with 6.3) had belonged at one time or another to organizations providing for the constructive use of leisure.

On the matter of the differences in the types of crime committed by the two groups, there is readily at hand only the evidence furnished by the offenses for which they were brought before the Boston Juvenile Court. Here we see that 69 per cent of the delinquents of lower intelligence had com-

[1] This includes the appearance before the Boston Juvenile Court if no arrests had occurred previously.

mitted property crimes; 13 per cent had been arrested for stubbornness, 5 per cent for running away, 3 per cent for truancy, and 10 per cent for various other offenses, such as assault and battery, disturbing the peace, evading fares, gaming, trespassing, vagrancy, and violation of license laws. In comparison a greater proportion of the delinquents of higher intelligence were before the court for the commission of property crimes (73.8); fewer for running away (4.3 per cent); an equal proportion for truancy (3.0 per cent); and fewer for stubbornness (9.6 per cent).[1]

Before proceeding to a comparison of the two groups in the matter of school history, let us see what early unsettling experiences of one kind or another had been the lot of fully half of these delinquents of both lower and higher intelligence. The occurrence of unusual environmental situations is readily understandable in view of the sordidness of the homes in which these children were reared and the many difficulties inherent in the family situations. Some of these youngsters were impelled to run away from home. In some cases the homes were disrupted for one or another reason and the boy went to live with relatives or was placed in a foster home or protectorate. In some cases the hand of the law reached in to remove them either because they were being neglected by their parents or by reason of their own delinquent acts. And in others early undesirable environmental experiences had occurred in the nature of frequent uprootings of the household because of the great mobility of the parents. Whatever the reasons, these boys, both those of lower and those of higher intelligence, had experienced unusual environmental situations.

And now what of their school histories? Half of the youngsters of lower intelligence (48.0 per cent) had completed their formal education at the end of the sixth grade, only 9.6 per cent had finished eighth grade, and not one of them had entered high school. Of the delinquents of higher intelligence, almost one-third (29.2 per cent) had completed at least the eighth grade and 21.8 per cent had actually gone

[1] Because of the number of categories in the classification, it is difficult to analyze the differences between the two groups.

beyond to high school. The reasons for this difference are of course apparent. School dissatisfactions naturally play a considerable rôle in the case of children who cannot keep up with the scholastic pace. Only 17 per cent of the boys who really needed to be in special classes for mentally retarded children had been so provided for. Nine-tenths of these boys of lower intelligence were two or more years retarded in school (68 per cent, three or more years). As retardation in school may be due to numerous other causes than inability to do school work—such as frequent absence due to illness, eye strain, fatigue, lack of interest in subject matter, or conflicts of various kinds—we are prepared for the finding that the delinquents of higher intelligence were also somewhat behind grade for their ages, although not to nearly so great an extent. Only a little over half as many of those of higher intelligence were retarded two or more years (50.9 per cent as compared with 91.6). Ninety-two per cent of the delinquents of lower intelligence had either been truants or had otherwise misbehaved in school (82 per cent had been truants). The delinquents of higher intelligence did not show quite the same extent of school maladjustment, as the lesser proportion of 82 per cent had either been truants or otherwise showed school dissatisfactions (72 per cent had been truants). This degree of difference in school misbehavior probably has to do with the fact that the delinquents of lower intelligence had more difficulties in keeping the scholastic pace and that, as stated above, no special recognition had been given to their need for segregation in classes for retarded children.

In view of the very limited preparation of these young delinquents for careers in industry and their extreme youth at the onset of work experiences—nine-tenths of the youngsters both of lower and higher intelligence being fourteen and under when they began to earn money—the finding that in both groups four-fifths of those who had had industrial experiences prior to their appearance before the Boston Juvenile Court had been irregular, sporadic workers is entirely consistent. What differences may reveal themselves in the industrial habits of the delinquents of lower and those of

higher intelligence, the passage of time will show. Meanwhile, the two groups entered the industrial race equally unfit. An analysis of the early employment of these boys, however, is already somewhat indicative of the differences in their future courses. Practically the same proportion in both groups (58.9 per cent in the one and 57.7 in the other) entered the street trades—paper selling, bootblacking, peddling. But a smaller proportion (1.0 per cent as compared with 2.1) of those of lower intelligence gravitated early to trades as carpenters or plumbers' helpers, and more (3.6 per cent as compared with 1.9) were early attracted to earning money in illicit employments.

A word now as to the handling of the two groups by the courts. Of those who had been arrested, slightly fewer of the lower-intelligence group had experienced probation [1] (60 per cent as compared with 64.5); more had been committed to correctional institutions (13.1 per cent as compared with 10.0); and far fewer had had a charge against them filed (4.0 per cent as compared with 56.5). In view of the fact that most of the courts in which these offenders had appeared had no psychological service, it would seem as if the defective mentality of the lower-intelligence group had in some cases at least been easily recognizable by the judges and probation officers.

There are undoubtedly many other important factors in the lives of these young delinquents that might have been studied. Unfortunately this is the sum and substance of our knowledge of them. Before proceeding to a summary of the similarities and differences between the two intelligence groups, it should be said that 90 per cent of those of lower intelligence had continued to be delinquent after the end of court-clinic "treatment," while 84 per cent of those of higher intelligence had continued in their delinquent behavior.[2]

[1] Exclusive of suspended sentences.

[2] That the greater proportion of recidivists among those of lower intelligence is not atypical is confirmed by the findings of other studies. Of 500 male graduates of the Massachusetts Reformatory for Men, 85 per cent of those of lower intelligence continued to recidivate as compared to 80 per cent of those of higher intelligence (see *Five Hundred Criminal Careers*, p. 255); while in a group of 500 women graduates of the Massachusetts Reformatory for Women, 81 per

SUMMARY

And now the data are before us concerning the similarities and differences between delinquents of lower and those of higher intelligence as revealed in one group of 1,000 cases. I am fully aware of the necessity of a check on the findings and plan to study in like fashion a group of 500 female offenders. Meanwhile, a tentative conclusion is justified. Let us examine first the factors in which the delinquents of lower and those of higher intelligence were unlike one another. Even rather slight differences are stated, as they certainly mark a trend.

We see first that among the delinquents of lower intelligence there was a considerably greater incidence of mental defectiveness among parents or siblings, which is probably indicative of a greater biological inheritance of defectiveness; but there was less mental disease or peculiarity in the family history. The parents of the delinquents of lower intelligence had far less schooling and were to a greater extent illiterate. Their mothers tended to be a little younger at marriage than the mothers of the delinquents of higher intelligence; they had more children; a greater proportion of them had a feeling of indifference or of actual hostility to the particular boy in question. The disciplinary practices of both father and mother were ineffectual in a larger proportion of the cases. In more of the families of the boys of lower intelligence, other members (parents and/or siblings) were also delinquent. A greater proportion of the families of the delinquents of lower intelligence were constantly on the border line of actual dependency, and more of them kept boarders or lodgers.

In view of the greater amount of defectiveness in the families—which probably means a higher proportion of defectives among the fathers and in turn explains their more limited schooling—it is entirely consistent to find that there were more unskilled workers among the fathers than among the fathers of the delinquents of higher intelligence; that the

cent of those of lower intelligence continued to recidivate as compared to 70 per cent of those of higher intelligence. (*Five Hundred Delinquent Women*, unpublished table.)

families lived to a larger extent in homes that were overcrowded and contained only the bare necessities; and that these homes were to a greater degree in noisy and crime-breeding neighborhoods.

As to the boys themselves, a greater proportion of those of lower intelligence were highly suggestible or had poor emotional control or other liabilities of personality, but a lesser proportion of them were found to have abnormal ideations of one sort or another. More of them were found to be poorly developed physically—a fact that is probably related to the lower economic status of their families. The young delinquents of lower intelligence had had less schooling and were to a far greater extent retarded in their studies. A higher proportion of them had manifested difficulties in school, particularly in the form of truancy, and a greater proportion of them had left school because of inability to do school work. Fewer of the young delinquents of lower intelligence had ever belonged to any clubs or organizations for the constructive use of leisure time. Fewer had entered the skilled trades, and more of them had early found their way into illicit occupations.

There is some difference even in the character of the offenses committed by the two groups as reflected in the particular offense for which they were brought before the Boston Juvenile Court. Fewer of those of lower intelligence had committed property crimes, while a greater proportion had been arrested for stubbornness, destroying state property, running away, and similar offenses. The manner in which the law treats these offenders of lower intelligence—where it recognizes them—is indicated by the slightly higher proportion of commitments, the smaller proportion of "probations," and the far lower proportion of instances in which the charges against them were "filed." And the difference of which we make final note is the greater proportion of recidivists among young delinquents of lower than among those of higher intelligence after the end of the period of "treatment" by the Boston Juvenile Court–Judge Baker Foundation, which indicates that they responded even less than did delinquents of greater intelligence to this particular kind of

handling,[1] partly, no doubt, because the recommendations made by the clinic for their "treatment" were not carried out to as great an extent as in the group of delinquents of higher intelligence, the percentage carried out being 19.6 as compared with 26.8. The explanation of this latter situation lies mainly in the dearth of facilities for institutionalizing delinquents of lower intelligence who need it.

Before commenting further upon the significance of the differences in background and characteristics between delinquents of lower and those of higher intelligence, let us first see how the two groups resemble each other. In proportion of native born they are alike, and also in the proportion of native-born sons of foreign-born parents. They were the same average age at the time of the arrest that brought them before the Boston Juvenile Court and, in turn, to the Judge Baker Foundation for diagnosis. Equal proportions of them had been previously arrested and their first arrests had occurred at the same early age.

The two groups of youngsters had been reared in homes equally inadequate for the wholesome life of children, either because of early disruption of the family after the death, desertion, or separation of the parents, or because of other conditions that militated against a harmonious atmosphere. In equal proportions the mothers of the delinquents of lower and those of higher intelligence had been gainfully employed; the conjugal relations of the parents had been equally unpleasant; the fathers had been to the same extent either indifferent or actually hostile to their sons; and in a like proportion of cases social agencies had been involved in the handling of the many family problems.

Further resemblance between the two groups is found in the extent to which they had had early abnormal environmental experiences and in the early age at which they had been subjected or had exposed themselves to such unsteadying influences. They resembled each other also in the age of onset of misbehavior manifestations, in the extent of their harmful use of leisure, and even in the length of time that

[1] For a full description of which, see *One Thousand Juvenile Delinquents*, Chapters III, IV, VII.

elapsed between the onset of delinquent behavior and the first arrest, and the first signs of antisocial behavior and study of the case by the Judge Baker Foundation Clinic. And those who had already had industrial experiences prior to their appearance before the Boston Juvenile Court had been to an equal degree in both groups only sporadically employed. Finally, although more of those of lower intelligence were recidivists after the end of "treatment" by court and clinic (this includes the commission of offenses for which the offender was not arrested), those actually apprehended had on the average the same number of arrests and convictions.

Of course there are certain subtleties in these data which are not fully revealed, partly because of the smallness of the groups where categorizations are fine, and partly also because of the crudity of the twofold classification of intelligence. In future studies particularly directed to this question of the relationship of intelligence to delinquency, it would undoubtedly be worth the effort to make a comparative analysis, factor by factor, of a sufficient and equal number of cases on each intelligence level (superior, normal, dull, border-line, feebleminded, imbecile). But despite the deficiencies in the present effort, certain tentative conclusions regarding the relationship of intelligence to delinquency are justified.

CONCLUSION

This comparison of the background and characteristics of delinquents of lower and higher intelligence seems to suggest that such differences as do exist *definitely flow from the mental deficiency of the delinquents themselves and from the substratum of deficiency in their families.* How better account for such factors as the greater illiteracy of the parents, the poorer work skill of the fathers, the greater poverty of the families, and, in turn, the poorer physical homes and neighborhoods in which they lived, and the poorer general health of the young delinquents of lower intelligence, their greater school difficulties, greater retardation, and so on?

Further, it is evident that those factors in which delinquents of lower and those of higher intelligence *resemble* each other obviously could not be interpreted to hinge upon

the factor of mental deficiency in the boys or in the lesser substratum of deficiency in their families—nativity, culture conflict between native-born children and foreign-born parents, broken or poorly supervised homes, early onset of misbehavior tendencies, early abnormal environmental experiences, harmful use of leisure, lapse of time between onset of misbehavior and first arrest, and so on.

So we see among delinquents of lower intelligence all the subversive influences that we find among those of higher intelligence, and in addition in greater measure those factors which arise from the child's own deficiency or that of his family. *This certainly accounts for the fact that there are far more persons of low mentality in delinquent populations than in the general population. It suggests that mental deficiency, though not a direct cause of delinquency, is a complicating factor of great potency, the presence of which, in addition to other causative influences, severely breaks down the individual's resistance to antisocial behavior.* Although the writer realizes the hazard of any effort to gauge accurately as yet the expectancy of delinquency among those of lower intelligence as compared with those of higher intelligence, it seems reasonably safe to say that in the group studied and on the basis of the data presented in the table on page 551, such expectancy is at least five times as great as for those of higher intelligence.[1]

Although it is not possible as yet to make any comprehensive statement regarding the implications of these findings in relation to the formation of a social policy toward young delinquents of lower intelligence, it is nevertheless in point at least to outline a preventive, protective, and treatment program. It is obvious that the organized social agencies of a community must assume some kind of formal or informal guardianship over young delinquents of lower intelligence whose families are so obviously in most cases entirely unequipped to do so. Their limitations, economic, social, and psychological, are so great that they can hardly be expected

[1] Professor Edwin B. Wilson, of the Harvard School of Public Health, made the calculation necessary to arrive at this rough estimate, during an interview held with him on February 4, 1935.

to provide the necessary guidance for the children. Both for their own protection and for that of society, there seem to be only two courses open:

1. Institutionalization for an indefinite period in a school for defectives if the child is not safe in the community under careful supervision. Clinicians are usually able to select those young delinquents of lower intelligence who need institutionalization, the length of the period of social segregation naturally to be determined by the offender's response to treatment. Where there is marked emotional instability or very great suggestibility or psychopathy in addition to the low intelligence, certainly institutionalization must be considered for the protection of society.

2. Close supervision by qualified persons or organizations from the time that delinquent behavior first manifests itself. There is already sufficient evidence that many young delinquents of lower intelligence respond well to supervision and can safely be allowed to remain in the community.[1]

In the case of the particular group under discussion, the Judge Baker Foundation definitely recommended commitment to schools for the feebleminded for one-fifth and sentence to correctional institutions for another 12 per cent, a total of one-third in all as compared to one-tenth of the delinquents of higher intelligence for whom commitment seemed socially desirable.

Schools for the feebleminded and institutions for defective delinquents have a unique opportunity to define the types of treatment best suited to young delinquents of lower mentality and they can also lead the way in suggesting the extra-institutional handling of such delinquents as do respond to supervision. How a supervisory service should be organized in a community is an open question. It would seem best, however, to avoid the possibility of stigmatizing children of lower intelligence with delinquent tendencies by not creating a single supervisory agency. Some kind of central committee

[1] See *Five Hundred Delinquent Women*, p. 253.

or council or clinic for the consideration of such cases, which would be referred by the schools, by parents, by social agencies, and by probation officers, could assign such children to the guidance of persons or agencies particularly well suited to render such service, with the continued advice, however, of the central case council, committee, or clinic. A well-organized school system with good clinical facilities ought to be able to catch in the net all young delinquents of the lower grades of intelligence and to see that they are suitably handled.

Certainly, the proper treatment of juvenile offenders of the lower grades of intelligence would greatly reduce the problems of crime and recidivism. In view of our present social structure and the limitations in our knowledge of crime causation, an approach such as suggested above at least promises the greatest possible amount of social security and is obviously also in the best interests of the young delinquents of lower intelligence.

School systems of course have a particularly important rôle to play in this problem of the supervision of children of lower intelligence who manifest behavior difficulties because, after all, the school represents the first contact of the child with organized society. In view of the present tendency to segregate children of lower intelligence in special classes, those who have such children in charge are faced with the fact that among these children there is a greater proportion of potential delinquents than would be found in classes of children of higher intelligence. The problems created by such a concentration of children of lower intelligence are many, not the least among them being the high degree of suggestibility of children of lower intelligence, so that those with behavior problems among them are a graver menace than they might be among children who are not so suggestible. This means that teachers who handle mentally retarded children must be particularly skilled, not only in recognizing early the potential delinquents among them, but also in protecting the other children from forming antisocial habits. It is also necessary, if young delinquents of lower intelligence are to be kept in the community, for

school systems constantly to modify and readapt their curricula to meet the specialized needs of such children. Much is to be learned in this regard from the teaching methods now being developed in schools for the feebleminded. And because of the greater likelihood of delinquency among children of lower intelligence, those who handle mentally retarded children have a great contribution to make in the field of crime prevention by experimenting with methods of teaching emotional control and the dangers of oversuggestibility. They also have a vast field of experimentation in the development of the right kind of inhibitions in children of lower intelligence. For example, it is necessary, in the case of girls particularly, to guide them in the management of the sex impulse and to teach them the dangers of its mismanagement. It is of the utmost importance that schools should be as closely as possible linked with the home, the contacts being maintained by the teachers themselves in smaller systems and in larger systems by visiting teachers especially assigned to this work. Schools must give the closest kind of supervision to the child of lower intelligence who manifests delinquent trends, at least during the school hours and in coöperation with the particular person or agency in the community that has assumed the responsibility for his oversight. Even more than in the case of young delinquents of higher intelligence, it is necessary to keep these youngsters in school longer, off the streets, and constantly occupied, and to prepare them carefully for vocational life.

There are of course many facets to this problem of the handling of young delinquents of lower intelligence to the best interests of their own and the social protection. Details of a policy toward them can be sketched in only as our knowledge of delinquency, its causes, and its treatment increases.

Meanwhile, the broad outline of a social policy toward them is already indicated if it is recognized that:

1. There is a far higher proportion of children of lower intelligence among delinquent groups than in the general population of children.

2. The likelihood of delinquency among children of lower intelligence is greater than among those of higher intelligence.

3. The families of young delinquents of lower intelligence are even less able than of those of higher intelligence to participate constructively in any program for the supervision and treatment of such children.

COUNSELING STUDENTS ON PRE-MARITAL PROBLEMS

A FUNCTION OF THE SOCIOLOGIST *

M. F. NIMKOFF, PH.D.
Associate Professor of Sociology, Bucknell University

IN the course of his life every person is called upon to make three basic adjustments. In the order of decreasing generality, these are the adjustment to the universe as a whole, the adjustment to his fellow man, and the adjustment to one person in particular, his mate.[1] Yet there is one important difference between the first two—namely, adjustment to God and adjustment to the herd—and the third, adjustment to a mate. In the case of the first two, adjustment is relatively even and continuous. In the case of mating, it is more climactic and critical.

The continuous development of the affectional life wells up in adolescence and comes to a head in marriage. The preoccupation of college students with love and mating is apparent; it is the most dynamic and absorbing interest that they have. There is no other course in the curriculum, therefore, that can come closer to touching the immediate interests of college students than the course on the family. This puts the teacher of the family course in a strategic position as student counselor.

It is interesting to trace the development of the course on the family in the American college and to note the increasing tendency toward concern with the marriage and pre-marriage adjustments of students. The early family course was almost entirely devoted to the history of the family as a social institution. Then the emphasis shifted to an objective study of modern social problems affecting the family. Still the subject matter was remote from the students' immediate needs.

* Read before the Section on The Family, at the Annual Meeting of the American Sociological Society, Chicago, Illinois, December 28, 1934.

[1] *The New Psychology and the Parent*, by H. Crichton-Miller. New York: Albert and Charles Boni, 1923. p. 54.

Lately there has been evidence that more attention is being given to the personal aspects of family life, the relation of family life to the development of personality, and the interaction of parents and children and of husband and wife. There is clear indication, then, that the need of students for guidance in their own pre-marriage experiences is being more widely recognized in the organization of the family course to-day.

For all this improvement, there is still room for progress. Probably most courses on the family are still of the formal sort, unrelated to the experience of the students, present or prospective. As the result of investigation, Hornell Hart gives it as his opinion that the actual content of the college course on the family lags behind both the immediate practical needs of students and the trend in the literature of the family toward a greater emphasis on the personal aspects of family experience.[1] And, in comparison with the number of courses on the family, of whatever content, the number of college teachers of such courses who now do systematic, careful counseling on student problems is relatively small. Indeed the whole personnel movement is still new in the college. Not until the issue of January, 1928, do we find the *International Index to Periodical Literature* providing a special subdivision on "Advisory Service" under the larger head of "Colleges and Universities."

For the purposes of this paper, however, the writer will assume two things, neither of which is necessarily true: first, that the teacher of the family course is qualified, both in his own personality and in his training as a technician, to act as a counselor on student problems; and second, that the teacher is permitted by his college administration to carry on this service. Assuming both this ability and this opportunity to act in the capacity of counselor, the question becomes: What are the legitimate functions of the teacher of the family course as counselor on student pre-marriage and marriage problems?[2]

[1] "Trends of Change in Textbooks on the Family," by Hornell Hart. *American Journal of Sociology*, Vol. 39, pp. 222–30, September, 1933.

[2] Since the course on the family is generally given in departments of sociology, the term "sociologist" and the phrase "teacher of the family course" will be used interchangeably. Also, since the family course is taken primarily by undergraduate students, major emphasis in this discussion will be placed upon premarital rather than marital problems.

This paper develops the thesis that the sociologist as consultant has a distinctive function: to define social situations and to show their significance for human personality. By "a distinctive function" the writer means that the sociological consultant has a work to do which is unlike that of the practical psychologist, the psychoanalyst, or the psychiatrist. If each of these experts has a different part to play, this must be because of differences in the problems with which they deal or differences in their approach to problems. We can, therefore, gain some insight into these differences by giving thought to student pre-marriage problems themselves, and by inquiring whether there are differences in the nature of these problems which call for difference in type of treatment.

The pre-marriage problems of students (and possibly all personal problems, for that matter) may be considered as being of two kinds: problems of integration and problems of orientation. A great many pre-marriage problems are combinations of these two types. Integration, a familiar term in psychology and psychiatry, has reference to the normal and harmonious development of the emotions. A problem of integration would thus be one involving emotional disturbance or imbalance. The emotional disturbance may be very slight or very severe, but as a rule the phrase "poorly integrated" is not applied to a personality unless the emotional maladjustment is of a pronounced degree. Orientation, on the other hand, is a term with social connotation. A person is oriented when he is in proper relation to a social situation. A problem of orientation arises when the person does not fit smoothly into the situation of which he is a part, when he is not accommodated to the situation.

As was suggested above, integration and orientation are often two aspects of the same problem. The person who for one reason or another is not well oriented socially may become disorganized as a person; that is, his orientation problem may give rise to a problem of integration. Most emotional imbalance is probably of this origin, the result of unfortunate social experience during the early years of life or of critical situations in later life. Conversely, if already poorly integrated, the person is handicapped in making new social adjustments that will be adequate. That is, problems of integration lead to problems of orientation. However, the

two situations may exist quite independently of each other. It is possible to be maladjusted emotionally as a result of biological or inherited conditions; and it is possible, too, to be maladjusted socially without this resulting in an acute condition of emotional upset.

In dealing with a student's pre-marriage problem, it is important for the counselor to evaluate it in terms of integration and orientation. Quite probably every problem that a student brings is a problem in orientation, for to have a problem—to acknowledge that one has a problem—is to be lost in, or uncertain about, a social situation. Often, however, the problem that the student brings is much more than a problem of present social adjustment. A great many so-called pre-marriage problems of students turn out upon analysis to be primarily personality problems. The pre-marriage difficulty of which these students complain is nothing other than a fundamental personality adjustment showing itself in this present pre-marriage guise. The difficulty was there before the pre-marriage experience was entered into, and the chances are that the difficulty expresses itself in situations other than this one of pre-marriage. To deal with the pre-marriage situation alone would be to deal with surface conditions rather than with underlying causes.

Take, for example, the case of student Miss A. B. On the surface, hers was a pre-marriage problem. A sophomore twenty years old, she said that she had fallen in love with Mr. C. D., a non-college man of twenty-five, and wished to marry him. Her guardians objected strenuously to the projected marriage. Ought she to marry in the face of their objection? This was the way she stated her problem.

Offhand it might seem that this was a simple question, merely one of deciding whether or not her elders were reasonable in their opposition. Miss A. B. gave the consultant to understand that her guardians objected to Mr. C. D. chiefly because of his low economic and educational status. After two years of high school, he had gone to work in a silk mill, and had ever since been employed at manual labor. The story of how they met and of how he courted her makes interesting reading, but the tale is not pertinent here.

Investigation showed that Miss A. B.'s real difficulty lay in directions other than those to which she herself pointed. When she was only an infant, both her parents died and she was adopted by two spinsters. They reared her in rural isolation according to a cheerless and frugal philosophy of life. She was deprived of normal association with boys. To make matters worse, Miss A. B. turned out to be a homely girl, and there was much evidence to show that she was extremely sensitive about her lack of physical charm. She became crotchety and suspicious of the

motives of even her best friends in their efforts to help her. Her consciousness of her defects was intensified by her coming into a college community where pretty, smartly dressed girls were plentiful.

Ignored by the college men and disdained by the more popular co-eds, Miss A. B. struck up an acquaintance with Miss F., another campus misfit, a girl who had achieved a brilliant scholastic record, but who had not made a good social adjustment. As so often happens, this bright, unpopular student encouraged Miss A. B.'s attentions, compensating in this way for her own sense of inferiority. For Miss A. B., however, the relation soon came to have homosexual significance. At this turn of affairs, Miss F. became alarmed and cut loose from Miss A. B.

About this time Mr. C. D. appeared upon the scene, an unattractive-looking young man of average intelligence and of below average moral standards. It is possible, however, that he was genuinely interested in Miss A. B. Although not attracted to him as a person, she was both flattered and flustered by the attention he paid her. Here at last was a man who took notice of her and thought her desirable. Though half afraid of him because fearful of all men, Miss A. B. permitted Mr. C. D. to carry on his wooing, and when he suggested that they become engaged, she consented. Not until the solitaire sparkled upon her finger and had shed its light quite deliberately into every corner of the campus, did Miss A. B. break the news of her engagement to her guardians.

Enough of this case has been given to show what the writer means by a student pre-marriage problem that is essentially a personality problem. No attempt to deal with Miss A. B.'s pre-marriage situation that did not tackle the more fundamental maladjustments in her life could hope to accomplish much. A great many of the cases with which the college teacher of the course on the family has to deal are of this sort. It is probably correct to say that most of the vexing and critical pre-marriage problems are those that have their roots ensnarled in some personality twist.

Whether or not the teacher of the family course should by himself attempt to deal with deep-rooted personality maladjustments, depends upon a number of considerations, among them the unavailability of other qualified personnel workers, the unwillingness of the student to make a second emotional transference of his problem, and so on. If because of reasons such as these, and with a proper sense of his limitations for the work, a sociologist is constrained to deal with a fundamental personality disorder, I think we should not be too ready to criticize him for doing so.

However, in the writer's judgment, it is not the function of the sociologist to deal unassisted with problems involving

personality disorders. Few sociologists are qualified by study and experience in the fields relating to personality to deal with such difficulties by themselves; the majority of them may well enlist the assistance of the psychiatrist. However, the sociologist is in a position, in turn, to supplement the services of the psychiatrist.

What the sociologist can contribute is an interpretation of the meaning of social situations for personality. In the A. B. case, for example, he can show the relationship between Miss A. B.'s social experience and her wishes, attitudes, concepts of self, behavior patterns, philosophy of life, and so forth. He can show the relationship that existed between her strong desire for response and her rôle as an orphan and as an adopted child. The sociologist is sensitive to group life and its effect upon personality. He is attentive to the rôle that a person plays in the various groups to which he belongs, from which ideas of self are built up.

The psychiatrist, on the other hand, is trained in the discrimination of mental states—can, for example, differentiate among various sorts of mental confusion, tell delusions from illusions and both from hallucinations. He can tell whether Miss A. B. has one sort of delusion or another—delusions of grandeur or delusions of persecution, and so forth. He can, therefore, define the client's mental condition, tell what it is and indicate in what directions it is tending. The psychiatrist thus focuses upon mind, the pattern; the sociologist upon social experience, the process, and upon attitudes, the product. Apparently this is the distinction that Professor Burgess had in mind when he spoke "of the psychiatrist, with his understanding of *the form* of the emotional disturbance, and of the sociologist, with his interest in *the content* of the mental conflict to be studied in its context in the social situation."[1]

Indeed, it is important to point out that many so-called pre-marriage or marriage problems include much more than marriage values only. Not a few pre-marriage problems are complicated by problems of inheritance, or health, or vocation, and so forth. For example, a student brings such a problem as the following:

[1] *The Cultural Approach to the Study of Personality*, by Ernest W. Burgess. MENTAL HYGIENE, Vol. 14, April, 1930. p. 316.

> "My maternal uncle has been in an insane asylum for the past five years. My maternal grandfather committed suicide. There are other irregularities in my family background. I am engaged to be married. I have not told my fiancé about my family. Have I a right to marry?"

A case study of this girl's family tree is needed to determine (1) whether it carries a real taint; (2) if so, whether this taint is to be accounted for in terms of inheritance or social experience; (3) whether this girl herself shows the blemish; and (4) if so, whether it is a blemish that forbids parenthood, but permits marriage. Clearly, for a case of this sort, the services of a eugenist are required.

In other cases, the pre-marriage problem turns out to be a problem in part of vocational adjustment. A student, let us say, wishes to marry, has two jobs in mind, but does not know which of the two to take. He favors one and his fiancée favors the other. She feels that if he takes the position he has in mind, his true interests will be violated. It might be of help to have him complete first the Strong vocational-interest blank and then, according to the results indicated, take various tests for the measurement of special work aptitudes. In giving such tests as these and in giving mental and personality tests, it is advantageous to have the services of a psychologist. And so it goes, the services of specialists in various lines being helpful when special problems are indicated.

The services of these specialists may be utilized in either of two ways. First, the sociologist may refer the student directly to the required technician. Second, a group of specialists on the campus may organize for purposes of counseling. Such coöperation results in efforts less disjointed, in treatment better coördinated, and in a clarifying transfer of viewpoints. Under these circumstances the benefits obtained should be superior to those achieved under a system of occasional special reference.

Although there are few cases in the treatment of which the sociologist cannot be benefited by the assistance of experts in other fields, he often can function without such assistance. This is the case in connection with pre-marriage problems that are essentially situational in nature. In these problems the main issues are centered in the pre-marital experiences themselves; the social problems are not complicated by additional

and often more fundamental maladjustments. Mr. L. and Miss M., for example, would like to be married upon their graduation from college this June. Mr. L. has a position assured him, so there is no problem of financial support. The two young people are apparently genuinely fond of each other, but he is a Catholic and she is a Protestant, and the parents on both sides do not favor the match. This is a very sketchy account, of course, but it serves our present needs. What shall these young people do? There is no problem in the lives of either which is being projected into their relationship; it is the relationship itself that is the problem.

What the sociologist can do for these young people is to define their situation for them. He can, to use a popular phrase, give them "the lay of the land." Why does the problem exist for them? How do their respective parents actually feel about the affair and why? How do they themselves actually feel about their relation, about their parents, and about their parents' objections? In other words, the sociologist helps them to analyze the situation for themselves in terms of the values and attitudes involved. This means that the teacher must know the values that belong to such a situation. He should know the positions of the Catholic and Protestant churches on mixed marriages. He should know something about how marriages of this sort have actually turned out—under what circumstances they have prospered, under what circumstances they have failed. The consultant must supply all the special information for which the problem calls. Further, he may help the couple to identify for themselves the various courses of action open to them, the possibilities and the difficulties of each. Thus the sociologist defines the social situation by making the young people aware of the pertinent attitudes and values involved.

Although this problem is chiefly situational in nature, the writer does not intend to suggest that it is without its psychological aspects. Every situation that involves values involves attitudes also; and attitudes are psychological data. But they are normal mental states with which the sociologist is able to deal. If, however, one of the people referred to above should happen to have a strong religious compulsion, with ramifications extending throughout other compartments of

experience, then it might be necessary to have the services of a psychiatrist. Or, again, if the indecision over the marriage should be of long standing, so that one or both of the young people developed a pronounced mental conflict leading to dissociation, then again the psychiatrist might be useful. However, the writer feels that the teacher of the family course is ordinarily the person best qualified to counsel on pre-marital problems that are essentially situational and cultural in nature.

Indeed, in this realm the sociologist has a decided advantage over the other students of personality, for he is better qualified to interpret the meaning of social situations. As an illustration, take one of the most common problems that students bring for advice: Is it wise for two persons who love each other to have sex experience in advance of marriage? The writer feels that on such a question as this, the sociologist trained in the field of the family is entitled to speak, because the problem is essentially a cultural one and lies in the field of his specialty. Although there are other considerations, the first objection to sex intimacy before marriage is to be found in the more or less powerful taboos against such conduct inherent in our mores. In certain primitive societies, and in certain quarters in our own society, the mores are hospitable to such intimacy, and the young people suffer less from this problem. If a psychologist were advising on this question, he might suggest such intimacy for the fulfillment of personality, for the avoidance of repression and resulting tensions. He might adopt the slogan of the personnel department of one of our large universities: "Before all else . . . the individual: his welfare, his opportunity for development." But the sociologist knows where victory generally lies in an open conflict between sex desires and sex mores. Further, he knows this conflict to be but one of the vital elements involved in this problem; and it should be the strength of the sociologist that he is able to delineate the total social situation. A good painter is not one who leaves out of his scene what should be there, and a good consultant is not one who only half defines the situation.

To make this point concrete, let us take a specific case involving this sex problem:

Miss Y., twenty-two, a college senior, has been engaged to Mr. Z., twenty-five, for two years. They have known each other over a period of six years, and seem well suited to each other. Mr. Z. was graduated last June from the college that Miss Y. now attends, and is a first-year student in medical school. Here his expenses are being met by his parents. Both Miss Y. and Mr. Z. are of English-American stock and of the comfortable middle class. The parents on both sides are favorable to the relationship. These two young people, however, do not know what is the right course for them to follow. They would like to be married when Miss Y. is graduated this June, but Mr. Z.'s parents are opposed to his marrying before he is economically self-supporting. That, he says, postpones marriage until an indefinite time in the future, since after graduation from medical school there must come a year or two of interneship, to be followed by time-consuming endeavor to build up a practice. What should they do?

These two young people had been advised by a physician to live together without benefit of clergy. Was this an adequate solution of their problem? Whether one feels that the advice was sound or unsound, it must be acknowledged that the definition of the situation was a very partial one. Not all the possibilities were faced. Indeed, not all the implications of the one possibility were explored.

How might the social situation of these young people have been defined for them? In terms, first, of the various possibilities open to them and, second, of their own attitudes and the attitudes of their families toward these possibilities.

To illustrate such definition, there are four possibilities open to Miss Y. and Mr. Z.: (1) they may separate, giving each other up, so that Miss Y. may be enabled to meet some one else and marry sooner, and Mr. Z. may complete his course without conflicting thoughts of marriage; (2) they may continue as at present, enjoying each other as persons and waiting for the good wedding day to come; (3) they may accept the advice of the physician and live together before marriage; (4) they may marry, either convincing their parents of the wisdom of this course so that the parents will continue to support them after marriage in the manner in which they are supporting them now, or they may defy their parents and take a chance on being able to get along.

No one of these choices is all sunshine and no shadow. This is one of those problems to which there is no solution in the sense that all the difficulties vanish with the turning of the

right key. Each of the courses open to Miss Y. and Mr. Z. entails grave disadvantages. The first course, of having no entangling alliance while doing graduate work, recommended by the National Research Council,[1] makes no appeal whatsoever to this couple. They would not think of giving each other up.

As for the second course, waiting, they would be willing, but it is hard, taxing, "soul-rending." The urge to possess each other completely is, they say, fairly irresistible. Why so? Are they of especially ardent natures? Do they permit themselves easily to get into situations that offer temptation? In a word, is their feeling for each other one that has been artificially stimulated, the result of poor sex education in childhood and adolescence? Can their feeling be moderated without injury in case they decide to wait? In brief, so far as waiting is concerned, do they need sex expression or sex education?

If they decide on course number three, pre-marriage expression, what will be the situation? Under what circumstances will they come together? How will they feel about their conduct? What will be the effect of enforced secrecy upon their companionship? What will they do in the event of conception?

If they decide against this course and decide to marry (course number four), what can they do to try to win over their parents to their point of view? Failing this, what would happen if they were to marry just the same? Would the parents relent, once the marriage was a reality? If not, could they manage financially without parental support?

Here, then, are a few of the high spots in the attempt to survey "the lay of the land" for this couple. There are many more questions that could be raised for them. There are many more questions that could be raised for each possible choice, and each question in turn would involve a number of considerations. It should be clear that it is no simple thing "to see life steadily and see it whole."

It will be observed that in clarifying the problem for these students, no attempt is made to settle the matter for them.

[1] *An Open Letter to College Seniors*, by Carl E. Seashore. Washington, D. C.: National Research Council. p. 10.

The writer believes it is the function of the consultant to define the social situation, but not to decide it. The student will ordinarily come wanting to be told what he ought to do. Often he comes with his mind already made up on what he will do, and eager for confirmation. But it seems to the writer that the consultant should beware. He should avoid the necessity for a commitment at the beginning by listening long and patiently to the student. That veteran mental-hygienist, Dr. A. H. Ruggles, has pointed out how often the consultant fails at the very outset by not knowing how to listen. Only in this way can he secure the emotional transference necessary for successful handling of the case. This is the psychoanalytic technique, but it will not hurt the sociologist to use it. After a state of empathy has been achieved, the consultant can by skillful questioning lead the client to define his situation for himself. In this way the problem is put back upon the client where it belongs, and a continued relationship of abject dependence is avoided.

To be sure, by the questions the consultant raises, by the emphasis he gives certain facts, by the special information he supplies, he definitely influences the choice that the client makes. He influences the choice, but he does not make it. Thus the student is not deprived of the feeling that the decision is his own and the incentive to action that comes from a consciousness of self-determination.

We have seen the need that exists for the counseling of students on family problems, also the extent to which and the way in which the sociologist, as a teacher of the family course, is qualified to meet this need. There remains a very practical, but ineluctable problem, the problem of time. When is the poor, overburdened professor to function as a counselor? This work is time- and energy-consuming. Goodwin Watson, on the basis of his experience in training psychological counselors, estimates that from twenty to thirty hours will be required for adequate testing of a student and as much more for the taking of a well-rounded case history.[1] Then the work has only begun. Next comes the diagnosis; then the planning and execution of a course of treatment; and finally the

[1] See *The Demand for Psychological Counselors in Education*, by Goodwin Watson. MENTAL HYGIENE, Vol. 15, July, 1931. p. 548.

terminal follow-up study. Student counseling is not a matter of a friendly pat on the back and a five-minute pep talk between classes. It calls for long hours of time. The sociologist who acts as a counselor on the pre-marriage problems of students must be relieved of other responsibilities if he is not to become a case for the psychiatrist himself.

A REORIENTATION FOR STATE-HOSPITAL PSYCHIATRY *

MINNA EMCH, M.D.

Senior Physician, Worcester State Hospital, Worcester, Massachusetts

THE constant increase in state-hospital population attendant on an increased incidence of diagnosed psychoses in the general population is fast approaching a point where legislative appropriations can scarcely provide for the maintenance of such standards of "custodial care" as have generally prevailed in the past decade. The United States Bureau of the Census reports that from 1904 to 1928 the number of patients in state hospitals more than doubled, the increase continuing in the following years. In 1930 the excess of population over capacity in these hospitals was 12.7 per cent. Had it not been for the necessity of governmental economies in recent years, an era of further building and expansion might have ensued, but the rationale of such a program is open to serious question.

Dynamic psychology teaches the necessity of an individualized therapy, based on a knowledge of the particular problem involved in each patient's emotional reactions and social attitudes. Such knowledge can no more be obtained through mass handling of similarly diagnosed patients than could adequate social histories be prepared from routine questionnaires submitted to their relatives. Inevitably, mass methods have resulted in a large hospital residue of chronic patients, making up the bulk of a case load which divides the physician's efforts into therapeutic nullities. In addition, a greater degree of public enlightenment has resulted in increasingly early hospitalization of neurotic and psychotic persons. Such patients expect and deserve something more than the limbo of permanent removal from all contact with the life of the community. . It was in an effort to discover

EDITOR'S NOTE: Awarded the second prize for original research by the New England Society for Psychiatry in 1935.

how such a therapeutic end might best be attained with the facilities at hand in a large institution that the present study was undertaken on the female psychiatric service of the Worcester State Hospital.

A Survey of the "Chronic"[1] *Population.*—On first consideration, it appeared that on the basis of minimal evidence of psychosis, a group of 250 so-called "parole" patients constituted the logical point of attack for a program of social rehabilitation. These women live on wards where a minimum of supervision is given, are entirely amenable to hospital routine, and when physically able, give several hours of service daily in some hospital industry for which their training and experience fit them. They are permitted to come and go on the hospital grounds during the day and are allowed other privileges afforded by the hospital or nearby city in accordance with the degree of responsibility which they are considered capable of assuming.

Analysis revealed that, in fully half of these cases, hospitalization had occurred from five to thirty years before, and that the patients had, after a period of more or less acute excitement, entered a quiescent state in which evidence of psychosis was either entirely lacking or could be elicited only by persistent questioning and constant observation. In a certain number the incipient deterioration of the senium was superimposed on the "faded" psychosis; in others, minor peculiarities of dress or behavior remained as the only evidence of the previous psychotic episode.

Accordingly, the case of each parole patient was reviewed, and, when indicated, the possibility of placement outside the hospital was considered after conference with relatives or social agencies that might be expected to aid in the individual's readjustment in the community. A committee composed of psychiatrist, social worker, and occupational therapist conducted this survey over a period of approximately six months.[2]

[1] This term is not used to suggest an unchanging clinical picture, but rather to indicate long and continuous hospitalization, without reference to clinical manifestations of the psychosis.

[2] Acknowledgment is here made to Miss Alice Paine, social worker, and the Misses Mildred Stuart and Barbara Folk, occupational therapists, for their interest and valuable assistance.

The primary consideration was the justification for each patient's continued residence in the hospital. Yet, if there was enough evidence of psychosis to warrant continued hospitalization, the question still remained as to whether the patient was receiving the benefit of all the hospital had to offer, or was, on the contrary, by reason of the very chronicity of the problem, being forgotten in the rush of new problems. For the physician this question led to more complete physical, neurological, and laboratory investigations, with the use of indicated modern therapeutic measures. The occupational therapist considered the patient's industrial adjustment in the light of past ambitions and present needs, and changes of occupation were planned to foster greater interest and independence. The social worker had a most important contribution to make. In some instances this consisted of getting salient information to round out the inadequate histories of a decade or more ago; in other cases, of tracing relatives who had long before "forgotten" the patient's existence, and in convincing them of the importance of letters, visits, and other expressions of interest. This work in itself was of great influence in changing certain fixed attitudes of patients' relatives toward the whole subject of mental disease.

Of this "parole" group, there were 125 patients whose continued hospitalization was considered unjustifiable on the basis of present evidence of psychosis. In other words, these patients were using hospital beds and taking a large part of physicians' time for required routine examinations and interviews, when, as a matter of fact, their psychiatric problems had long before faded into inaccessibility. They had become institutionalized individuals whose outgoing interests and community contacts had been, or were fast being, destroyed. Here a triple problem presented itself: first, to find a situation in which the patient might be placed; second, to convince the patient of the desirability of such a change; and third, to convince relatives and social agencies of the advisability of the placement, in the face of their dire forebodings as to what might come of it. Force of habit and a sense of retreat from the world fostered by years of hospitalization had created in these patients fear of and resistance to leaving the hospital. This had to be overcome by reassurance and insistence

on a trial placement. Relatives, too, had to be reassured, cajoled, and lectured. Their objections were numerous and had to be met by the social worker's detailed knowledge of special circumstances and loyalties. Social agencies were generally enlightened in their attitudes, but it is interesting to note that their policies have become even more liberal as they have become better acquainted with state-hospital problems and have come to realize that our purposes are in no way inimical to their own.

The types of placement that could be made were the following:

1. Discharge to relatives, county farms, or state infirmaries.
2. Trial or indefinite visit with relatives or in custodial homes (fraternal orders, homes for aged, etc.) from which the patient may be returned at any time within a year. This visit period may be extended at the discretion of the physician.
3. "Family care"—*i.e.*, placement in a supervised home at state or private expense. The patient is responsible to the caretaker, but the atmosphere is that of a home, and the patient group does not exceed four or five.

Of the 125 cases considered suitable, it was possible to make 112 placements, as follows: 21 patients were discharged, 56 were placed on trial visit, and 35 were placed in family care.

At the end of one year, the disposition of these cases was as follows:

Of the 21 patients discharged outright, none had been returned.

Of the 56 patients on trial visit, 20 had been discharged, 14 had had the visit period extended, and 22 had been returned.

Of the 35 patients in family care, 2 had been discharged, 25 had remained in family care, and 8 had been returned.

There had been no suicides, homicides, or serious behavior difficulties.

Judged by the criterion of an adequate adjustment outside the hospital for at least one year, 82 of the 112 placements had been successful, 30 unsuccessful. In general, however, it is considered that family-care placement lasting more than one year represents only a more comfortable (though certainly more normal) mode of life, and is thus merely better

custody rather than therapy. If, in accordance with this point of view, the 25 patients remaining in family care are not listed among the successful placements, the number is reduced to 57, little better than 50 per cent of the total placements, or 45 per cent of the 125 patients considered suitable for placement. When against these figures are balanced the time and effort required to make the necessary contacts, prove legal residence after a long lapse of years, and change rigid attitudes in both patients and relatives, the results seem of questionable value from the point of view of the original objective. Especially did the time and effort seem uneconomically spent when one considered the ultimate result—*viz.*, elderly persons, living comfortable, but in the main dull and unproductive existences in partial or entire dependence on relatives or on the community.

A New Program of Therapy.—How, then, was the problem to be approached next? It seemed that if even greater emphasis were placed on therapy and social readjustment of newly admitted patients through a reorganization of service facilities, our objective might be more directly attained, both in reference to ultimately cutting down the chronic residue and giving more individualized effort to the handling of acute problems.

At the beginning of this study, there was, on the female psychiatric service, one admission ward of 28-bed capacity. New patients, if they were neither assaultive nor noisy, were admitted to this ward and kept under "observation" for one month. At the end of that time they were discharged or absorbed into the hospital population, either on the parole wards previously described, or on locked wards of from 50- to 80-bed capacity, housing patients of various degrees of disturbance or deterioration. It is evident that relatively few newly admitted patients are ready for the unrestricted activities of parole wards within one month after admission, so that for varying periods of time, they were, perforce, housed with the population of the locked wards, a situation in which the possibilities for supervised activity and stimulating contacts are negligible. More important was the case of the acutely disturbed newly admitted patient who could not be kept on the admission ward despite hydrotherapy and other

sedative measures. Such patients had to be transferred to other large wards in which they were among the most disturbed chronic population in the hospital. Interviews with these patients in less disturbed periods gave ample evidence that they had been by no means oblivious to their unpleasant surroundings and that the impressions received gave rise to an apprehensive retreat from or even greater resistance to this unpleasant reality.

It was thus immediately apparent that two more types of wards were necessary: the first for acutely disturbed newly admitted patients, the second for the convalescent care of patients who were not yet ready for parole responsibilities. With the advice and coöperation of the executive heads of the hospital, three wards which had been used for chronic patients were remodeled and redecorated for our purposes. For the disturbed patients, a ward with an original capacity of 20 beds was reduced to one of 11 single rooms. Two other wards, communicating floors in a pleasant circular unit of the building, were arranged, one for the convalescent care of depressed and suicidal patients, and the other for young schizophrenic patients. Each ward was placed in charge of a psychiatrically trained graduate nurse, with student nurses acting as her assistants. Individual and group work in occupational therapy, music, eurhythmic dancing, and social and outdoor activities were instituted as part of each day's routine on these wards as well as on the original admission ward. In this way the "treatment ward" capacity was increased from 28 to 100, and on the patients in these wards was concentrated every therapeutic influence that the hospital could offer.

The case-work on new admissions emphasized (1) a complete social history; (2) complete physical and laboratory studies with neurological and other consultations as indicated; (3) establishment of the deepest possible rapport between the patient and her physician, so that the patient's problems and attitudes might be exhaustively investigated and extended psychotherapeutic interviews instituted when it was deemed advisable in view of the patient's degree of intelligence and accessibility; and (4) therapeutic interviews with relatives when these were considered necessary in the

light of factors discovered in the treatment of the patient. When improved, patients were permitted to leave the hospital to go into situations judged to be suitable from the point of view of therapy. When the home situation was unsatisfactory, family care was used either while further efforts were being made to improve the family situation or until the patient was able to find work that would make her self-supporting. Hospital supervision was maintained either through regular interviews with the physician at the hospital or by social-service visits to the home. When special circumstances made it advisable, other medical or social agencies were asked to coöperate in placement and supervision. The material of the balance of this study comprises one year's admissions to the female psychiatric service treated in accordance with this program of therapy in the "treatment wards" above described.[1]

Results of the Program of Therapy.—The year's admissions, comprising 312 cases, were subjected to analysis with specific reference to results of hospital and social treatment as evidenced by degree of adjustment one year after admission to the hospital.[2] The terms used to designate disposition of cases are the following:

1. *Discharge*
   a. Outright—denoting absence of or recovery from psychosis, with further hospital supervision considered unnecessary.
   b. From visit—denoting a year or more of adequate adjustment in the community under hospital supervision.
   c. For transfer—denoting merely a change of residence to another institution, without reference to the patient's mental state.
2. *Visit* [3]
   a. Trial—denoting visit of definite period (week, etc.) under constant supervision, to determine an initial reaction to leaving the hospital.
   b. Indefinite—denoting visit under supervision which is terminated either by discharge at the end of one year or return within that period.
3. *Family care* (previously defined)
4. *Escape*
5. *Uninterrupted stay*—denoting no visits or other absences of one month or over since admission.

[1] Exceptions were made only for those patients whose physical condition was such as to require bed care on general medical wards.

[2] Readmissions were not separately tabulated throughout, but a comparison with first admissions is presented in Table IV.

[3] For purposes of this study, no visit lasting less than one month was tabulated.

6. *Death*
   a. After uninterrupted stay
   b. After return from visit
   c. While on visit.[1]

TABLE I.—DISPOSITION AT END OF PERIOD OF STUDY OF ONE YEAR'S ADMISSIONS TO FEMALE PSYCHIATRIC SERVICE OF WORCESTER STATE HOSPITAL.*

Disposition	*Number of cases*		*Per cent of total*
Discharged:			
Outright	75		
From visit	46		
For transfer	8		
Total		129	41.3
Out of hospital:			
On visit	37		
In family care	10		
On escape	1		
Total		48	15.4
Returned to hospital:			
From visit	14		
From family care	5		
From escape	3		
After discharge	3		
Total		25	8.0
Uninterrupted stay		49	15.7
Deaths:			
After uninterrupted stay	57		
After return from visit	3		
While on visit	1		
Total		61	19.5
		312	100.0

* The period of study ended one year after the admission of the last patient in the group, or two years after the admission of the first patient in the group. Such figures do not of course remain static. In three months after the termination of this period, there were the following changes:
  14 additional discharges (9 from visit)
  6 additional visit placements (2 from family care)
  2 additional family-care placements
  1 return to the hospital after discharge
  3 returns from visit.
The balance is still obviously on the credit side.

The major diagnostic groups were next tabulated according to the disposition of cases within each such group. Those listed as "without psychosis" include only patients for whom no qualifying classification (such as psychoneurosis, mental

[1] In this series, one arteriosclerotic patient, removed at the request of relatives, died eleven months after leaving the hospital while still on visit.

TABLE II.—DISPOSITION BY DIAGNOSTIC GROUPS OF ONE YEAR'S ADMISSIONS TO FEMALE PSYCHIATRIC SERVICE OF WORCESTER STATE HOSPITAL *

Diagnosis	*Outright discharge*	*Discharged from visit*	*Out on visit or in family care*	*Out one month or over and returned*	*Stay uninterrupted*	*Died*	*Total*
Without psychosis	10	..	..	..	..	..	10
Epilepsy	3	..	..	..	..	..	3
Psychopathic personality	9	1	..	1	..	..	11
Mental deficiency	12	4	4	1	2	1	24
Psychoneuroses	12	3	6	..	2	..	23
Manic-depressive psychoses	1	7	5	2	3	..	18
Involutional melancholia	..	1	2	..	4	..	7
Schizophrenia	2	12	18	7	23	2	64
Paranoid condition	2	3	3	2	2	..	12
Alcoholic psychoses	8	5	..	1	..	1	15
Acute organic reaction types	1	2	1	..	..	10	14
Senile and arteriosclerotic psychoses	1	5	6	6	8	36	62
Other chronic organic reaction types	1	3	2	2	5	7	20
Total	62	46	47	22	49	57	283

* Twenty-nine cases not included for reasons given in text.

deficiency, psychopathic personality, etc.) was made. Where such descriptive or classificatory phrases were appended, the case was so tabulated. In the acute organic reaction types only the toxic psychoses and those associated with somatic disease were included, the alcoholic psychoses being separately considered. The chronic organic reaction types included psychoses due to syphilis and other organic brain diseases not separately designated. Cases left unclassified, transferred to other institutions, or out on escape were not included in this tabulation.

Of the 312 patients admitted, 74 remained in the hospital at the termination of the period of study, 49 having had no absences of one month or over, and 25 having been returned after an absence of one month or over.[1] Of these 74, 71 classified cases were further tabulated according to diagnosis and numerical ratings indicating degree of adjustment in the hospital and, conversely, degree of personality disintegration or organic deterioration.

Class 1 includes patients who show no present evidence of psychosis and are considered well enough to be out of the hospital under supervision, but for whom a satisfactory situation has not yet been found.

Class 2 includes patients who are making a parole adjustment, but who show enough evidence of psychosis to warrant further stay in the hospital.

Class 3 includes patients who, though actively psychotic, are making a reasonably good institutional adjustment, residing on non-parole wards and working in supervised hospital industries.

Class 4 includes patients who are actively psychotic and make a poor institutional adjustment, residing on non-parole wards and idle.

Class 5 includes patients in whom regressive personality changes, or mental and physical deteriorative changes on a basis of organic disease, have taken place.

Patients who had had previous admissions either to this or other state hospitals, numbering 67, constituted 20.9 per cent of the admissions during the period under consideration. Thirteen of the 67 were received by transfer from other hospitals within the state, six of the 13 being returned to their respective institutions after the completion of medical, surgical, or obstetrical procedures for which they had been admitted. These six, and two first admissions transferred to other institutions, may properly be omitted from the fol-

[1] Visit, family care, or escape.

lowing tabulation, which then compares the disposition of 61 cases in which there had been prior hospitalizations with that of 242 first admissions.

Discussion. — Although, in the tabulation of diagnostic correlates, adjustment ratings, and readmissions, the number of cases in any one group may be relatively small, certain tendencies may be indicated, even when exhaustive implications may not be drawn.

TABLE III.—ADJUSTMENT RATINGS, BY DIAGNOSTIC GROUPS, OF PATIENTS REMAINING IN HOSPITAL, AMONG ONE YEAR'S ADMISSIONS TO FEMALE PSYCHIATRIC SERVICE OF WORCESTER STATE HOSPITAL

Diagnosis	*Class 1*	*Class 2*	*Class 3*	*Class 4*	*Class 5*	*Total*
Schizophrenia	1	4	3	21	1	30
Senile and cerebral-arteriosclerotic psychoses	4	..	2	2	6	14
Other chronic organic reaction types	1	1	..	2	3	7
Manic-depressive psychoses	2	1	..	2	..	5
Paranoid condition	..	1	2	1	..	4
Involutional melancholia	..	..	..	3	1	4
Psychoneuroses	..	1	..	1	..	2
Mental deficiency	..	..	1	2	..	3
Alcoholic psychoses	1	..	..	..	..	1
Psychopathic personality	1	..	..	..	..	1
	10	8	8	34	11 *	71

* Of the 11 patients in Class 5, 8 require bed care on the medical wards.

As might be expected from its incidence the country over, schizophrenia constitutes the largest single diagnostic group. As in national statistics, so here, it comprises more than 20 per cent of the year's admissions. Exactly half of this group of patients were able to adjust successfully outside the hospital, whereas the majority of the remaining half were making a poor institutional adjustment. Such figures, scarcely more than a chance division, indicate the extent of the challenge that this psychosis presents to forward-looking psychiatrists, and the necessity for the development of new therapeutic techniques through psychological and psychosomatic researches.

A group almost equal in number, but far different in institutional history, is that comprising the senile and cerebral-arteriosclerotic psychoses. Of these, more than half the patients died before a year had passed—many within the

first month of hospitalization, some within the week after admission. There was slight necessity for many of these "ante-mortem commitments," which serve to call to notice a practice by which general-hospital death rates are reduced at the expense of the receiving institution. The balance of this diagnostic group is responsible for a large item in medical costs, requiring constant bed care and nursing attention. The advisability of special custodial institutions for

TABLE IV.—COMPARISON OF FIRST ADMISSIONS AND READMISSIONS TO FEMALE PSYCHIATRIC SERVICE OF WORCESTER STATE HOSPITAL AT END OF PERIOD OF STUDY *

	First admissions		*Readmissions*	
Disposition	Number	Per cent	Number	Per cent
Discharged	96	39.6	25	41.0
Out of hospital †	33	13.7	14	22.9
In hospital ‡	54	22.3	20	32.8
Deaths	59	24.4	2	3.3
Total	242	100.0	61	100.0

* Eight transfers and one absence on escape omitted.
† On visit or in family care.
‡ Returned from visit, family care, or escape, or uninterrupted stay in hospital.

such cases might be considered as one step toward the removal of a custodial (and therefore non-therapeutic) atmosphere from state institutions.

Of the next largest group, that of the mental defectives, only a few had *bona fide* psychotic episodes. In most instances these patients had passed the age limit for admission to state schools and colonies, and could not be cared for in times of economic stress by communities which had formerly permitted them to remain illiterate, unskilled workers in mills and factories. Hospital effort here is largely in the direction of social case-work.

The psychoneurotics, constituting a group almost equally large, presented, on the other hand, problems in the main sufficiently accessible to psychotherapy so that commitment might have been avoided had psychiatric-treatment clinics for adults been available in the community.

In the foregoing statements no mention of recovery from psychosis has been made. This omission has been deliberate, because of the wide variation in the clinical use of the term and the controversial elements inherent in the entire problem of recovery from mental illness. There are psychiatrists who

admit the possibility of recovery from a toxic psychosis, but insist that schizophrenia, properly diagnosed, is capable only of various degrees of improvement, never of recovery. There are still others who repudiate the term in reference to general paresis and employ instead the unexceptionable "clinical remission" as permitting the greatest latitude in interpretation and prognosis. In any case, these considerations serve to indicate the contradictory and ambiguous elements that constitute the crux of the controversy. They are (1) the justifiability of considering a person recovered from psychosis in whom there has been a change of personality during an acute psychotic episode, and (2) relapse or recurrence of psychosis as vitiating a former so-called "recovery." The answer lies, obviously, in a rigid definition of terms in accordance with a revaluation of the clinical aspects of psychoses as related to the structure of personality, and in strict adherence to the definitive concepts agreed upon.

Pending such general agreement among psychiatrists, the ambiguity of the term "recovery" remains. It was, therefore, considered best to adopt an objective criterion of *social-economic adjustment* in preference to the orthodox "recovered-improved-unimproved" classification. It might be that patients known to have undergone an alteration of personality were nevertheless capable of useful adjustment in the community, while other patients, without observable abnormal tendencies, were still dependent because of physical incapacities or economic handicaps. But in very few known instances was abnormal behavior or mental incapacity sufficient to be alone responsible for complete dependence or inactivity of patients placed outside the hospital.

The criterion of social-economic adjustment does not, of course, rule out the possibility of recurrence or relapse, any more than such an eventuality could be ruled out in the case of tuberculosis or carcinoma. The point here taken is that such a possibility should not make necessary an indefinite or permanent hospitalization, if a suitable social situation is available in which supervision and therapy can be continued as necessary. In the comparison of first admissions and readmissions,[1] the analysis of the latter, constituting a group

[1] See Table IV.

more than one-fourth the size of the former, indicates that despite general prejudice to the contrary, the community-adjustment possibilities of readmitted patients are not far different from those of first admissions, and are considerably above the results for the continuously hospitalized group previously surveyed in the original "parole" group.[1] It seems, therefore, that despite recurrences which may have necessitated return to the hospital, the interim of life in the community might be looked upon as having carried over certain therapeutic effects into the later period of hospitalization.

Now the test of this program of therapy rests ultimately on the comparison of the results obtained in the year's admissions with those of the chronic group. The placements that may be related to the program of therapy number 187,[2] of which 168 were successful as judged by the criterion of a year or more of satisfactory adjustment in the community. Subtracting from the total of 312 admissions the 61 cases of patients whose physical condition was such that they died within the year,[3] and the eight patients transferred to other institutions, there were then 243 patients to whom this therapeutic program can be said to have applied. The 168 successful placements constitute 69 per cent of this number,[4] as contrasted with 45 per cent in the chronic group. To continue the comparison, what were the ultimate results achieved—*i.e.*, what were the types of social-economic adjustment which enabled patients to remain out of the hospital? The following analysis indicates to some extent the degree of responsibility which 150 patients[5] were known to have assumed.[6]

It is apparent that in only six instances was active expres-

[1] See above, pp. 589–90.

[2] Absence on escape and transfers to other institutions omitted.

[3] There were no suicides, homicides, or accidental deaths in this series.

[4] The ten family-care placements listed for this group were considered therapeutic rather than custodial. Two patients are adolescent girls who are being sent to school and two others have become self-supporting and have been placed on visit status since the termination of the period of study.

[5] Eighteen patients could not be traced. They were among the group discharged outright as requiring no further supervision and were considered capable of self-support on discharge.

[6] Acknowledgment is made of the interested effort and valuable assistance of the social-service department (Miss Helen M. Crockett, Director) in the placement and supervision of these patients.

sion of psychosis sufficient to interfere with social adjustment, and in four of these cases, a partial work adjustment in the home had been made. In the case of both minors later committed to correctional schools, there had been previous sentences for delinquencies. The later commitments occurred despite intensive social-treatment efforts. Thus, the large majority of these patients were leading useful lives in the

TABLE V.—SOCIAL-ECONOMIC ADJUSTMENT OF 150 PATIENTS RELEASED FROM HOSPITAL AMONG ONE YEAR'S ADMISSIONS TO FEMALE PSYCHIATRIC SERVICE OF WORCESTER STATE HOSPITAL

Housewife in full charge of home	71
Working and supporting self and/or dependents	46
Physically partially incapacitated, but doing own housework	12
In school	5
In custodial home (town farm, fraternal order) and working there	4
Actively psychotic, but assisting with work in own home under supervision	4
In general hospitals	2
In tuberculosis sanitaria	2
In correctional schools (minors)	2
Actively psychotic and receiving custodial care in own home	2
Total	150

community, despite a period of hospitalization which, a generation ago, might have doomed them to a futile and inactive existence. Lest it be thought that consideration of the patients' best interests worked to the exclusion of all other interests, it should be said that in every case a careful evaluation of the effects of home placement on other persons in the family group (particularly children) was made. Psychiatric and social treatment of non-hospitalized members of patients' families was frequently undertaken long before placement was made.

CONCLUSIONS

No program of this kind can continue long without effecting a change in every aspect of the institution in which it is inaugurated. Hospital personnel is educated to new attitudes, with the patient's reaction considered in advance of any change of procedure. New approaches to the problem of mental disease are utilized in the attempt to investigate all phases of psychosomatic relationships, and therapy rather than custody becomes the ultimate goal. It is further evi-

dent that this program, involving as it does the necessity of dealing with the preconceived ideas and prejudices of individuals and communities, must in the long run be an important factor in changing public sentiment toward mental disease. Its effect should ultimately be to do away with the notion that mental diseases are "incurable" and the "asylum" a "living death." If the state hospital remains in any sense a haven or retreat, it must nevertheless take for its ultimate goal the preparation of the patient for a return to society. Such an orientation will make of state hospitals the centers of active treatment and research that they must become in order to deal effectively with the ever-increasing problems arising from the impact of present-day civilization on the psyche.

THE SLEEP OF YOUNG CHILDREN IN A TWENTY-FOUR-HOUR NURSERY SCHOOL

MARTHA MAY REYNOLDS

Professor of Child Study and Director of Nursery School, Institute of Euthenics, Vassar College

LITTLE enough is known about the sleep needs of adults and even less about those of young children. Authoritarian statements that a three-year-old child should have so many hours of sleep each night cause anxiety to parents of three-year-olds who take less than that amount. Nor are parents the only ones perplexed by the discrepancy between theory and practice. Nursery-school teachers are concerned over the amount of sleep that the children have each day and set about it to *do* something when a child falls below the accepted standard for his age. Both at home and at school, the problem of the sleep of the pre-school child assumes great importance. It is, therefore, worth while for us to give consideration to the results of any study that throws light on this problem.

The study reported in this article was made at the Institute of Euthenics at Vassar College during the six weeks of the summer schools of 1931, 1932, and 1933.[1] The conditions there were unusually favorable for making a study of sleep because the children were under the care of the teachers twenty-four hours a day, seven days a week, and a full-time staff, consisting of two psychologists, a pediatrician, a nutritionist, a recorder, and twelve nursery-school teachers did everything possible to provide optimum conditions for each child's growth. The number of children was small enough and the number of teachers large enough to allow variations

[1] The results for 1933 are included for the first time in the present article. For results obtained in 1931 and 1932, see "The Sleep of Young Children," by Martha May Reynolds and Helena Mallay, in *The Journal of Genetic Psychology*, Vol. 43, pp. 322–51, December, 1933.

in the daily program of the school to meet individual needs. Moreover, each child had an individual sleeping room. There are few other places where well children of pre-school age are cared for by such an imposing array of experts and where scientific records of their sleep can be accumulated over so long a consecutive period.

The method used was simply that of keeping an accurate record of the time when a child was put in bed, the time when he went to sleep, and the time when he awoke. The study was necessarily limited to the quantitative aspects of sleep. The actual recording was done by the teachers, who were accustomed to keeping records of this sort, and was checked each day by the psychologist. Dr. Gertrude Porter Driscoll was in charge of the teachers and Miss Helena Mallay supervised the collection and tabulation of the data. The work of the author of this paper was that of collaborating and interpreting the results.

The subjects of the study were 77 children between the ages of seventeen and seventy-two months, who presented the usual problems of adjustment. None of them were in any sense serious deviates from the norms and, on the whole, the group was considered to be made up of "average" or "normal" children.

Comparison of the Sleep of Children of Different Chronological Ages.—Table 1 gives the data for the two-, three-, and four-year-olds, 59 in all. The results for the other 18 children were omitted from this portion of the study because the numbers in each age group were too small to be significant. The figures for 1931, 1932, and 1933 have been combined in obtaining the mean length of sleep and pre-sleep time for the two-year-olds, three-year-olds, and four-year-olds.

Several interesting points are suggested by the figures. In the first place, the average amount of sleep taken by the children between the ages of two and three was approximately twelve hours and a half; by those between three and four, eleven hours and a half; and by those between four and five, eleven hours. Each period is less than the amount of sleep usually recommended by authorities as desirable for children of pre-school age, but since the recommendations have been based on expert opinion rather than on the results of experi-

mental investigation, the weight of the evidence may be in favor of the results of this study.

It is apparent that the figures from the Vassar study should be interpreted cautiously in determining standards for the sleep of young children. Other factors, as yet unmeasurable, such as physical condition, season of the year,

TABLE 1.—AMOUNT OF SLEEP AND PRE-SLEEP TIME OF CHILDREN OF DIFFERENT AGES

	Age group		
	2 years through 2 years, 11 months	3 years through 3 years, 11 months	4 years through 4 years, 11 months
Number of children..	17	26	16
Total sleep:*			
Range	11:12—13:06 †	10:38—12:20	10:27—11:48
Mean	12:26	11:32	11:00
Night sleep:			
Range	10:23—11:48	10:00—11:17	9:50—10:59
Mean	11:04	10:40	10:24
Nap:‡			
Range	1:07—1:56	0:52—1:37	0:15—1:23
Mean	1:29	1:17	0:57
Pre-sleep time at night:			
Range	0:42—1:28	0:33—1:40	0:32—1:33
Mean	1:03	1:08	1:00
Pre-sleep time at nap:‡			
Range	0:15—0:47	0:18—1:01	0:27—1:15
Mean	0:26	0:35	0:38

* Total sleep includes day and night sleep in twenty-four hours.
† The figures are given in hours and minutes. For example, the range of total sleep was from 11 hours, 12 minutes to 13 hours, 6 minutes.
‡ Nap means actual sleep. Each child had a rest period of at least an hour every day, but these figures apply only to the days on which the child actually slept.

and emotional stability, undoubtedly affect the amount of sleep a child takes. And, furthermore, it may be unwise to assume that under present-day conditions, the amount of sleep a child takes is the amount of sleep he needs. But even with these limitations of interpretation, the figures from the Institute of Euthenics study make it pertinent to question whether the old standards were not too high and, therefore, the cause of anxiety and tension over the formation of the so-called fundamental habit of sleep.

The second interesting point brought out by the figures concerns the length of time it took the children to go to sleep. Authorities have made parents and teachers feel that if a child did not fall asleep twenty minutes after he was put to

bed, some one (besides the child) was at fault. When children of all three ages at the Vassar nursery school took approximately one hour to go to sleep at night, the question may well be raised whether the twenty-minute standard is not a fictitious one. Think of the relief to anxious mothers and conscientious fathers, if they could but feel that the hour that Junior takes to go to sleep is not too long after all.

But to return to the children of the Vassar nursery school, a comparison of the pre-sleep time at night with that at nap shows that, while at night the average was an hour, at nap time it was only half an hour, approximately. The reason for this discrepancy is not clear, but Mary Wagner, in her study, *Day and Night Sleep In a Group of Young Orphanage Children,*[1] has suggested that for children who have but one nap a day, the time between a child's awaking in the early morning and his being put to bed for a nap is longer than that between awaking from his nap and his regular bedtime. The amount of active waking hours may, then, determine to a considerable extent the length of time it takes a child to go to sleep, and the hypothetical twenty minutes descends further into insignificance.

In the light of these conclusions, is it not time for doctors and psychologists and teachers to give serious consideration to the sleep standards that they are urging parents to follow? And should there not be a revision of our attitude toward children's sleep similar to that which has taken place in the field of children's eating? If we are not careful, we may find ourselves with a crop of "sleep problems" of our own making on our hands, children who are the victims of overanxiety on the part of parents unable to make them sleep in accordance with our hypothetical standards.

Variations in the Sleep of Individual Children.—A study of the sleep of the individual children showed two interesting facts which appear to have a bearing on the fundamental motivation for children's sleep. The first point is that the variations in amount of sleep taken by a child from day to day were large; the second, that the variations in the weekly, biweekly, or triweekly averages for that same child were surprisingly small.

[1] *Journal of Genetic Psychology*, Vol. 42, pp. 442–59, June, 1933.

Somehow, we have become accustomed to think of the twenty-four-hour interval as the one in which to measure most physiological functions. Such phrases as the daily bath, the daily bowel movement, the daily calorie and vitamin intake—familiar phrases, all of them—show how completely we are accustomed to think in terms of the twenty-four-hour unit. Therefore, it was expected that the records of the present study would show a fairly stable amount of daily sleep for each child. Wide variations between the sleep of different individuals of the same chronological age were anticipated, but when the records for each child showed differences of from one and a half to three and a half hours, a careful study of this aspect of the problem was made.

Under ordinary home conditions, unusual events like a birthday party, a long ride in the country, a "hot dog" or an ice-cream cone, or any of the thousand other upsetting circumstances of family life would be offered as the reason why Johnnie slept less last night than he did the night before, but the conditions of the Vassar College nursery school were so constant that most of the usual reasons did not apply. It was necessary to look further for a plausible explanation of the wide variations.

And the variations were not only wide, but inconsistent. There were no group or individual tendencies for increased or decreased sleep. In other words, there were no times when the group as a whole slept outstandingly less or more than usual, and no child[1] who consistently gained or lost sleep during the six weeks of the Institute. The fluctuations seemed to be largely an individual matter.

For this reason, administration changes could not be counted on to explain both the losses and the gains. Much as the staff of experts wanted to increase the amount of sleep taken by the children while under their care, it had to be admitted that in only one case did they meet with signal success. And that success was nullified by a child who showed an even greater loss in the amount of sleep he took.[2]

[1] There were two exceptions to this statement. One child, a so-called sleep problem, had an average for the sixth week of the school sixty-five minutes higher than for the first week, and the other child, seventy-six minutes lower.

[2] See note 1 above.

No, something else besides good teaching and smooth-running administration was the real explanation of the large daily fluctuations which seemed to be individual.

Table 2 gives the figures for the daily amount of sleep taken by one child during the six weeks of the school, and illustrates the point that the changes were neither consistent gains nor consistent losses. This picture was repeated by practically all the other children who were the subjects of the study.

Since the twenty-four-hour pattern did not seem to be applicable to the children's sleep, an attempt was made to discover whether there was a constancy in the amount of sleep taken over weekly, biweekly, or triweekly periods. The selection of the weekly unit was arbitrary and no claim is made that it is the ideal one; it was simply the most convenient for this study. The aim was to find out how serious it was for a child to lose sleep and how long it was before he made it up. When the weekly, biweekly, and triweekly averages were computed for the 71 children whose records were used for this part of the study, the following facts stood out:

1. Sixty-six children, or 93 per cent, showed differences of less than thirty minutes between the average for the first three weeks and that for the last three weeks.
2. Thirty-eight children, or 53 per cent, showed differences of less than thirty minutes between their averages for the first two weeks, the second two weeks, and the third two weeks.

In other words, if thirty minutes is considered a negligible difference, at least half of the children made up their "lost sleep" in two weeks and practically *all* of them in three weeks.

It is true that these figures should be interpreted with caution, but it is equally true that they may indicate a tendency in the organism to maintain a fairly constant sleep balance over a longer period of time than the twenty-four-hour span. Further work is needed to test this hypothesis, but these figures are at least suggestive of certain trends.

One explanation for this tendency of the organism to satisfy its sleep needs in fairly constant fashion can be found in the physiological drive for rest and sleep. There is nothing new

about this; it is only that recently we have come to distrust the fundamental drives as motivations for children's behavior and have tended to overemphasize the influence of immediate conditions.

When a child does not go to sleep early, we have looked for an external cause—overstimulation, the effects of daylight saving, or poor handling—and only to a limited degree have we taken account of the child's sleep balance, as I would call it. The results of this study seem to indicate that one

TABLE 2.—DAILY AMOUNT OF SLEEP TAKEN BY ONE CHILD DURING SIX WEEKS OF SCHOOL

	First week	*Second week*	*Third week*	*Fourth week*	*Fifth week*	*Sixth week*
1st day	11:33	12:15	*	11:15	11:10	11:30
2nd day	10:23	11:15	11:17	11:00	11:19	12:47
3rd day	11:40	9:15	12:05	11:40	11:30	12:48
4th day	12:30	11:57	10:05	9:55	10:50	11:45
5th day	12:12	12:10	12:45	11:20	12:30	12:00
6th day	12:40	10:35	12:15	10:15	12:43	11:25
7th day	11:37	11:57	10:57	10:55	12:20	10:47
Weekly average. . . .	11:48	11:21	11:34	10:54	11:46	11:52
Biweekly average. . . .	11:35		11:14		11:49	
Triweekly average. . . .	11:34			11:31		

* The child underwent a tonsillectomy.

reason why a child does not sleep at any particular moment may be because he is ahead of himself on sleep and his organism does not need it just then. Who knows? It may be possible to store whatever it is sleep does for us in somewhat the same way as the body stores certain vitamins. "Lost sleep" may really be "sleep not needed" rather than "lost."

There is no justification in this theory for a *laissez faire* policy which allows a child to stay up late at night on the ground that it doesn't matter—he will sleep when he needs it. This is parallel to allowing a child to eat whenever and whatever he wants. Perhaps the organism will be adequately satisfied by both procedures—no one can really tell—but the child will become a social nuisance at least, without the solid foundation of well-formed fundamental habits. Sleeping, like eating, should be a means to an end, the maintenance of the

organism, so that life may be turned to more interesting things. Hit-or-miss habit formation is no more justifiable for sleeping than it is for eating.

On the other hand, we should be careful not to overemphasize the importance of immediate external conditions in forming proper habits of sleep. Painting the walls of the sleeping room a monotonous color, removing all traces of other occupations than sleep, are parallel, it seems to me, to serving a child's meal always from the same dishes or in other ways providing him with learning crutches of doubtful value. A certain amount of consistency is desirable when the habit is being formed, but in the case of sleep, we have probably carried the matter to extremes.

The application of the theory of the reliability of the physiological drive for sleep to everyday procedures with children could well parallel that of eating, and little harm should result if certain essential conditions are maintained.

First of all, regularity of rest and retiring hours should be maintained just as faithfully as regularity of mealtimes.

Second, conditions conducive to sleep should be provided, just as attractive surroundings and good food are provided to stimulate appetite.

Third, an adequately balanced day, with plenty of outdoor exercise and freedom from emotional strain in general, is necessary to prepare the organism for sleep, as it is for eating.

Fourth, there should be faith that when the above conditions have been satisfied, nature can be trusted to see to it that the child gets the sleep he needs. This will surround the whole matter of sleep with an atmosphere conducive to the formation of the proper sleep habits.

SOME FACTORS IN TRUANCY

MILTON E. KIRKPATRICK, M.D.
AND
TOWNSEND LODGE
Cuyahoga County Juvenile Court, Cleveland, Ohio

TRUANCY, when compared with other types of delinquency, stands, in one important sense, in a class by itself. The truant, as such, has neither overtly injured any one nor damaged any property. In contrast to other delinquents, his sin is primarily one of omission rather than commission. Nevertheless, the whys and wherefores of his problem clearly become matters of broad importance when one reflects that it is from this group of offenders that a considerable number of more serious delinquencies originate. That truancy is apt to be accompanied by other mischief, and that many cases of adult criminality have had histories involving early truancy, are commonplace observations.

What are the relations between the truant and the school? It is unreasonable, of course, to expect to find any single cause or set of causes that will fully explain all the types of behavior classified as truancy. The nature of a child's home background, previous experiences, health, associates, economic status, appearance, interests, and so on indefinitely, all contribute their varying influences upon his behavior and color his particular situation within the school environment. Conversely, the personalities of the teachers and the school officers interact with that of the child, to the end that his relationships with them—as in the case of any other social phenomenon—are infinitely complex. In spite of this, it is possible to examine some of the more outstanding facts associated with a large group of truants and thus, perhaps, to shed some light on the character of their adjustment to the educational milieu.

It is important to remember that truants do not represent a separate, clear-cut species of pupil. Rather, they are simply among those who deviate more widely than most from

what we consider a satisfactory range of school behavior patterns. Children who get along well in school are rarely truants, but comparatively few children who get along poorly at school give open expression to their unrest through truancy. There can be little doubt that the same factors that lead to truant behavior in these few cases also must be operating and contributing, more or less, to the development of unhygienic emotional mechanisms in the school lives of numbers of other children.

The principal aim of this paper is to consider the school situation of the truant group, in so far as it is reflected in matters of grade placement. How many truants are in school grades that enable them to maintain normal social relationships with their classmates from the point of view of life age and physical maturity? How well-equipped mentally is the truant to cope with the subject matter of his particular grade? If the conclusions to which we come are valid, we shall have a surer foundation, not only for improving our treatment of the actual offender, but also for approaching the much more important task of prevention.

In evaluating the data here presented, it should be borne in mind that those children who appear in court are not representative of the population at large, but that they come almost entirely from the lower economic strata. It has been found, for instance, that while the median monthly rental for families in the city of Cleveland as a whole is $36.25, the areas in which truants prevail have a median rental of $28.12. (Figures based on 1930 census.) Although children from the upper economic brackets seldom appear in court, this should not be taken as evidence that their virtue necessarily corresponds with their ability to evade entanglements with the law.

The following data are based on all the cases filed as truancies that appeared officially in the Cuyahoga County Juvenile Court from within the city limits of Cleveland during the years 1931–33, a total of 752 cases. Of these, 481 were boys and 271 girls. Records of the court indicate that a little more than one-eighth of all its delinquency cases during the years in question were of this type. Other cases, in which truancy figured only as a secondary offense, have been dis-

regarded in the present study. A comparatively small proportion of truants ever come to a stage involving any action on the part of the court; and these are ordinarily referred thereto through the Bureau of Attendance of the Cleveland Board of Education. This bureau handles a large number of truancy problems through its own personnel; others it brings to the court only for unofficial treatment. Thus, for example, in the school year, 1930–31, the Bureau of Attendance was concerned with 2,381 cases of truancy. Of these, only about 300 culminated in official court action, while approximately 300 more were brought before the court unofficially.

The Cuyahoga County Juvenile Court seeks to deal with as few cases as possible through formal, legal channels, with the view that whenever feasible, a child should be spared the stigma usually associated with an official court record. In an unofficial case, no delinquency affidavit is filed. The child and his parents are simply called before the court and warned that the latter stands ready to enforce the requirements of the school law. Although not governed by any hard-and-fast rule, this is the customary procedure in first and comparatively trivial offenses, petty thefts, occasional truancy, and so on. Experience has evidenced that this mild action frequently is all that is necessary to forestall future appearance.

TABLE 1.—SCHOOL DISTRIBUTION OF 752 TRUANTS, CLEVELAND, 1931–33

	Boys		*Girls*		*Total*	
	Number	Per cent	Number	Per cent	Total	Per cent
Type of school						
Public high.....	18	3.7	34	12.6	52	6.9
Elementary and junior high	104	21.6	192	70.9	296	39.4
Special.	45	9.4	18	6.6	63	8.4
Thomas A. Edison *	303	63.0	0	0.0	303	40.3
Parochial	11	2.3	27	10.0	38	5.1
	481	100	271	100	752	100

* For problem boys.

It will be noted in Table 1 that the percentages of boys from the regular public schools are much less than of girls. The reason for this lies in the fact that the Cleveland Board of Education, in an earnest and enlightened effort to redeem

problem boys, has provided them with Thomas A. Edison School, a large institution which draws its pupils from over the entire city; no such provision has been made for girls. This school aims to apply modern methods in education and lays considerable stress on the development of practical skills, yet at the same time seeks to give a boy as much as possible of the conventional curriculum. In many instances, it has undoubtedly had relatively tremendous success. Nevertheless, as is indicated in the table, 63 per cent of all the boys' truancies originated here. This disproportionate quantity should by no means be attributed solely to the boys' failure to get along in this particular institution. The school has attempted a task of appalling difficulty in striving to correct unhygienic behavior patterns that usually had been years in formation before they were suspected in the regular schools attended by the boys prior to their reference for special treatment.

TABLE 2.—AGE DISTRIBUTION OF 752 TRUANTS, CLEVELAND, 1931–33

	Boys		*Girls*		*Total*	
Age	Number	Per cent	Number	Per cent	Number	Per cent
6 years.....	1	0.21	0	0.00	1	0.13
7 years.....	1	0.21	3	1.11	4	0.53
8 years.....	5	1.04	3	1.11	8	1.06
9 years.....	5	1.04	3	1.11	8	1.06
10 years.....	5	1.04	5	1.85	10	1.33
11 years.....	14	2.91	5	1.85	19	2.53
12 years.....	17	3.53	0	0.00	17	2.26
13 years.....	28	5.82	10	3.69	38	5.05
14 years.....	89	18.50	42	15.50	131	17.42
15 years.....	156	32.43	93	34.32	249	33.11
16 years.....	110	22.87	73	26.94	183	24.33
17 years.....	50	10.40	34	12.55	84	11.17
	481	100	271	100	752	100

Table 2 shows that, so far as life age goes, frequency curves for boys and girls are closely parallel, and that the peak for both is very definitely in the sixteenth year. Nevertheless, girl offenders are apt to be a little older than boys. It is likely that the majority of truancies falling below ten or eleven years of age differ in quality from those that occur later. Truancies in the younger age range, as a rule, are closely dependent upon parental attitude; the child's parents

simply may not require him to go to school until they are forced to do so. In the case of the adolescent, on the other hand, there is the additional fact that many parents have completely lost control over the child's behavior.

Table 3 requires little comment though it is of interest to note that there are, in the schools, roughly 10 per cent more girls than boys in the ninth-to-twelfth-grade range.

TABLE 3.—GRADE DISTRIBUTION OF 752 TRUANTS, CLEVELAND, 1931–33

	Boys		*Girls*		*Total*	
Grade	Number	Per cent	Number	Per cent	Number	Per cent
I.....	3	0.62	1	0.39	4	0.53
II.....	6	1.25	4	1.48	10	1.33
III.....	9	1.87	7	2.58	16	2.13
IV.....	17	3.53	2	0.74	19	2.53
V.....	26	5.41	4	1.48	30	3.99
VI.....	21	4.37	8	2.95	29	3.86
VII.....	80	16.83	38	14.02	118	15.69
VIII.....	97	20.17	48	17.71	145	19.28
IX.....	103	21.41	68	25.09	171	22.74
X.....	29	6.03	33	12.18	62	8.24
XI.....	9	1.87	7	2.58	16	2.13
XII.....	1	0.21	0	0.00	1	0.13
Special class....	35	7.28	18	6.64	53	7.05
Unknown.....	45	9.36	33	12.18	78	10.37
	481	100	271	100	752	100

Even the most casual examination of Table 4 strikingly reveals that almost all truants have been subjected to one or more school failures. The average retardation is two years, and about one-fourth of the children are three or more years retarded. It is only reasonable to suppose that repeated failure produces far-reaching effects on the child's personality. Is it surprising if he develops an attitude of hopelessness and resentment toward the school or, in some cases, seeks to restore his self-esteem through open rebellion? Forced association with younger classmates in itself cannot help but have important reflections in his behavior, both in school and out. Three of our truants were retarded seven years. Can boys and girls who are rapidly nearing maturity be expected to derive profit or satisfaction from school when they are placed in grades primarily intended for an eight- or nine-year-old group? Although these are extreme cases, is

it not likely that similar considerations apply in varying degrees to most cases of life-age retardation?

A comparison in Table 4 of the percentages of boys and girls throughout the whole range of grade placements reveals a slight, but consistent tendency toward greater retardation among the boys than among the girls. It is of interest, in this connection, to observe that we have found evidence that girl truants, instead of being brighter than boys, are, if anything, a little duller. The average mental-age score of the fifteen-year-old boys was 12.2 years; of the girls, 11.6 years.

TABLE 4.—GRADE PLACEMENT OF 752 TRUANTS, CLEVELAND, 1931–33

	Boys		*Girls*		*Total*	
Grade placement	Number	Per cent	Number	Per cent	Number	Per cent
Advanced 1 year..	3	0.62	3	1.11	6	0.80
Right for age....	24	4.99	28	10.33	52	6.91
Retarded 1 year..	107	22.25	62	22.88	169	22.47
Retarded 2 years..	128	26.61	64	23.62	192	25.53
Retarded 3 years..	81	16.84	44	16.24	125	16.62
Retarded 4 years..	38	7.90	16	5.90	54	7.18
Retarded 5 years..	16	3.33	1	0.37	17	2.26
Retarded 6 years..	3	0.62	0	0.00	3	0.40
Retarded 7 years..	1	0.20	2	0.74	3	0.40
Special class.....	35	7.28	18	6.64	53	7.05
Unknown.	45	9.36	33	12.18	78	10.37
	481	100	271	100	752	100

In presenting the material relating to mental levels, it was decided, for several reasons, to make use only of the information at hand regarding the modal age group of truants—*i.e.*, the fifteen-year-olds—and to consider only those children examined by the court by means of the Stanford revision. These requirements were fulfilled in the cases of 67 boys and 37 girls. There seems to be no reason to suppose that these represent an atypical selection, although the use of small numbers clearly warrants caution. However, the same essential relationships were found to obtain in the data bearing on the fourteen- and sixteen-year groups, with an additional 99 cases. More complete treatment of this question would have been desirable; but although most of the children passing through the court have been given intelligence quotients, these are not all comparable, as they have been derived from a number of different sources.

The mean mental-age scores noted in Table 5 suggest that, in spite of being retarded for his life age, the average truant is still in a grade that is difficult for him. Assuming that a child in Grade VII, for example, normally has a mental age between 12 and 13 years, we discover from the table that the average fifteen-year-old, seventh-grade truant is short of this range by more than a half year. The table further shows

TABLE 5.—RELATION OF MENTAL LEVEL TO GRADE PLACEMENT OF 104 FIFTEEN-YEAR-OLD TRUANTS *

			Grade placement							
I.Q.	*Mental age*	Total	III	V	VI	VII	VIII	IX	X	Special
45–49	7.4	1	..	..	..	..	..	..	..	1
50–54	8.1	1	1	..	..	..	..	..	..	..
55–59	8.9	3	..	1	..	..	1	..	..	1
60–64	9.7	12	..	2	3	3	1	1	..	2
65–69	10.5	16	..	..	1	4	2	7	..	2
70–74	11.2	14	..	1	1	8	2	1	..	1
75–79	12.0	14	..	..	..	3	7	2	1	1
80–84	12.8	18	..	..	..	3	9	3	3	..
85–89	13.0	8	..	..	..	..	2	4	2	..
90–94	14.3	4	..	..	..	..	1	2	1	..
95–99	15.1	10	..	..	..	1	4	5	..	..
100–104	15.9	3	..	..	..	..	2	1	..	..
			1	4	5	22	31	26	7	8
Mean mental age		12.0	8.1	9.9	10.2	11.4	12.7	12.7	13.1	10.0

* Sixty-seven boys and 37 girls.

that eighth-grade boys and girls have mental-age scores ranging approximately from 9 to 16 years. Since these individuals are predominately in the lower half of the intelligence range exhibited by the general population, we should expect to find in all the Grade VIII classes in the city, mental-age differences of rather more than the seven years here indicated. The local educational authorities have long recognized the different degrees of ability coexistent at the same grade levels and a certain amount of provision has been made for this, such as Thomas Edison School, special classes, and differentiations within the regular grades. Nevertheless, one may well question whether it is possible for the curricular requirements of a given grade to differ in their intellectual demands in a way correspondent with the range of mental levels actually found in that grade.

Lastly, while we would expect to find some overlapping in the distribution of ability within the various grades, does not the table suggest this to be a little excessive? Fifteen-year-old truants with mental-age scores of about 11 years are found in all grades from V to IX inclusive. Eight fifteen-year-old truants in Grade IX have lower mental-age scores than one in Grade V. The inference from all this is that mental ability has not been a prime consideration affecting grade placement.

While Binet intelligence assuredly is not the only factor that should be weighed when a child is placed in a school grade, how many other factors are there of greater importance? If a child is to be expected to take an interest in school work, it would seem imperative that the latter fall within the limits of his comprehension. It is true that in the special classes, and at Thomas A. Edison School in the case of boys, there is a distinct effort to make allowance for this factor. But when we remember that truancy is mainly an adolescent phenomenon and that most of our truants have been in school a number of years before being transferred for special treatment, we can be reasonably certain that the relationship of ability to the required school tasks, during the early school years if not later, has had some bearing on their difficulties. The very fact that the group comprises so many chronic failures increases the probability that such is the case.

Leaving the question of intelligence levels, there is one further bit of data at our disposal that perhaps should be noted as related to the truant's attitude toward school. We have found that about one-fourth of all the parents of truants have had no schooling whatever. Over 50 per cent of the fathers and mothers had five years of school or less, and over 90 per cent had eight years or less. The significance of this is difficult to evaluate objectively; therefore, it is only mentioned in passing.

It seems justifiable to conclude, on the basis of the foregoing pages, that nearly all our confirmed truants have been misfits in their school grades in regard to their life ages, their mental ages, or both. While no claim is made that these factors are immediately responsible for the child's miscon-

duct, it is beyond doubt that they have played a significant part in the shaping of his unwholesome attitude toward the school. The implications of this extend deeper than simply in reference to truancy. The latter is to be thought of merely as symptomatic of a more basic disorder—namely, over-emphasis on subject matter in the schools and too little emphasis on the child as a person.

It is rather futile for a juvenile court to attempt to deal constructively with the truancy problem until the school curriculum has been modified to fit the child—in contrast to the present situation, in which the effort seems largely to be one of trimming the child so that he fits the curriculum. It is far more rational to keep truancy from developing in the first place than it is to try to correct it after it has once appeared. The factors discussed in this paper should be properly adjusted from the time a child starts to school. It is obviously impossible for a dull child to be where he belongs in regard both to chronological age and mental age at the same time, unless a radical revision takes place in the conventional system of grading. The school authorities are faced with a task of herculean proportions.

A MENTAL-HYGIENE SURVEY OF THE STATE TEACHERS COLLEGES OF MASSACHUSETTS *

HENRY B. ELKIND, M.D.

Medical Director, Massachusetts Society for Mental Hygiene

ABOUT two years ago Dr. Payson Smith, Commissioner of Education of the State of Massachusetts, and the presidents of the state teachers colleges extended me an invitation to study and survey these colleges from the point of view of mental hygiene. The opportunity was eagerly accepted; and the organization of which I am the executive was very glad to spare me for the work. As I could give only part time, I was allowed two years in which to complete my observations. An advisory committee of five was appointed,[1] to whom I might turn for advice and counsel. This committee has been very helpful in many ways. During the course of the survey, the various colleges were visited at least twice; members of the faculties were interviewed, singly and in groups; and at times I was invited to address a faculty meeting. Three colleges, Lowell, Westfield, and Bridgewater, were studied in particular. Every courtesy and sincere cooperation were given me by the presidents and faculty members.

The purpose of the survey was:

1. To ascertain what mental hygiene is being taught and how it is being taught.
2. To learn whether the pedagogy taught maintains a mental-hygiene point of view.

* Read at the Seventeenth Annual Conference of the Massachusetts State Teachers Colleges, Bridgewater, September 6, 1934.

[1] Chairman, Mr. Francis A. Bagnall, President, Framingham State Teachers College; Dr. Lawrence A. Averill, Worcester State Teachers College; Mr. Herman H. Brase, Lowell State Teachers College; Mr. Arthur C. Harrington, Fitchburg State Teachers College; and Miss Lillian M. Hoff, Salem State Teachers College.

3. To ascertain what is being done for the mental health of student teachers, and for their personal development.
4. To offer recommendations along these lines with a view to improvements in the curriculum or in personnel policies.

There has been no idea of curriculum making, but merely the hope that the suggestions offered may prove helpful in that connection. These are timely because changes in the curriculum are under consideration by the department at present.

Our conception of a survey is quite different from that on which many surveys are based. In our opinion a survey plan not only should fit the purpose of the survey and the kind of material it is to study, but should be the product of the thinking of the surveyor and of those surveyed. The first two essentials are obvious, although frequently overlooked; the last is not so obvious. If the thinking of all those concerned shows many divergencies, the surveyor should question his own premises and deductions and try to understand the true significance of the differences. If, however, he finds himself, after careful thought, in frank disagreement, he should have the courage of his convictions and state them, giving at the same time both his own reasons and the reasons of those with whom he cannot agree.

This survey, therefore, is non-statistical—it is impressionistic. Statistics would get us nowhere and might easily mislead. The purpose of the survey is avowedly promotional, but with an eye to the best interests of the colleges themselves and their student bodies. No single college is reported on; rather our aim has been to give a composite picture of the nine institutions surveyed.[1] Fortunately this is practical because, while no two colleges are exactly alike, there is a great deal of similarity about them. Furthermore, there is a tendency to standardize policy and practice.

The survey was early limited to the teaching of education, educational psychology, testing, hygiene, and physical and

[1] The Massachusetts School of Art was omitted. A few colleges are mentioned specifically by name when special courses in training are offered which are not given in any other college.

health education. It did not include the teaching of mathematics, science, history, or other academic subjects because mental hygiene has contributed very little to their pedagogy and because any new influence in evidence in the more general courses in education would percolate into the more specific courses such as those mentioned.[2]

The medical service furnished the student body was also considered in its relation to the general problem of student-teacher personality development.

We observed the practice or training schools and, in so far as was feasible, the field work. We also gave considerable attention to the faculty-adviser system, to matters of discipline, student health, selection of students, and the workings of student government where this exists. But the largest share of attention was given to the matter of student personality development.

In all our observations, we had in mind the varied professional interests of the student body, the needs of the elementary school-teacher, the teachers of junior and senior high schools, special-class teachers, and the like. We also kept in mind the special needs of the rural school-teacher.

Before presenting my findings and final conclusions and recommendations, it may be well to discuss briefly the question, What is mental hygiene? What is its special significance to education? That this be discussed is important, because what one gets out of or puts into a survey depends largely upon one's own point of view.

The aims of mental hygiene and of education, in our opinion, are identical. The end product of the educational process should be the happy child and eventually the happy adult. But this doctrine, without qualification, is inadequate and needs amplification and clarification.

[2] Of course, a teacher of natural science might consider the importance to mental health of the physical constitution and the nervous system. The relation between the physical and the mental sides of Man might be touched upon. The teacher of psychology could then omit these topics from his courses. Again, a teacher of history might develop a feeling in his students for psychological implications through analysis of the lives of historic personalities, or he might turn to social psychology to explain great movements in history. Or a teacher of literature might explain novel and biography in terms of psychological mechanisms. The possibilities in such teaching are legion, but require for their success considerable psychological experience and insight.

We do not mean that the happiness of the individual should be the sole aim of education; neither do we mean that the educational process should always be a pleasant one. What we do mean is that it should tend to produce a peace of mind, a strength of character, and a courage of heart that allow the enjoyment not merely of pleasure, but even of the overcoming of conflicts when these are imposed by necessity or in the pursuit of ideals. We believe that sacrifice and self-denial are as essential for good living as indulgence and self-satisfaction. Our concept of the educational process, in addition, appreciates the importance of respecting the rights of personality, in an ethical sense. These conceptions are closely related to prevailing philosophies of education.

One difference, however, between mental hygiene and education may be noted, although it is not a real difference, but rather one of emphasis. The mental-hygienist is particularly desirous of fitting the educational program to the specific needs of the child, although he would like also to adjust the child to the demands of his environment. The reason for this is easy to see: the mental-hygienist is especially interested in a reduction in the number of unhappy and maladjusted children and adults. The mental-hygienist's expectations, however, must be tempered by practical considerations. There is need of approach from the point of view both of the mass and of the individual through some practicable plan of compromise, and this has already been accomplished to some degree.

With these considerations in mind, we may now ask what place has mental hygiene as such in education and in particular in the curriculum of the state teachers colleges? In answering this we are bothered chiefly by words. A close study of the principles and practices of mental hygiene shows that in the main they are based on new ideas in the fields of psychology, medicine, psychiatry, and social work. We also find that these newer ideas are appearing on the horizon of education, and are being accepted by forward-looking educators, with the result that their concept of what the field of educational psychology should be has already changed. The older orthodox educational psychology focused its attention on the learning process as expressed in the laws of learning. There was, in addition, a distinct laboratory bias. At present,

educational psychology is realizing what mental hygiene early appreciated in its understanding of child nature—the influence on the learning process of such factors as the emotions, motivation, the personality, the state of the bodily health. Why, then, quarrel over words? Let us have the "new" educational psychology. That there is a "new" educational psychology is well demonstrated in the recent writings of Trow and Pressey.

There are, however, a number of topics that do not fit naturally or logically into the field of educational psychology even broadly conceived—such as mental disease and disorder, feeblemindedness, delinquency and crime, and the problem child. These might well be taught in a short course under the heading, "Mental Hygiene."

At the present time one notes a tendency to differentiate a positive from a negative mental hygiene. The reason for this seems to lie in a disinclination to accept a mental hygiene derived from abnormal psychology, psychiatry, and child guidance. Symonds, of Columbia Teachers College, makes much of this point. He states that "mental hygiene traditionally places more stress on how to correct poor mental adjustments or how to cure mental disorders than on how to prevent bad mental habits from arising. As related to education, mental hygiene has practically devoted its attention to the remedial treatment of the problem child."[1] What is needed, he believes, is a positive mental hygiene.

It is our judgment that it would be better—for the present, at least—to regard mental hygiene as an application of principles and practices that have come mainly from psychiatry and child guidance. Educational psychology on its part should not remain static. Contributions from medicine, psychiatry, psychology, and social work, where pertinent, should make their contributions toward the progress of educational psychology. There is no need of developing a new discipline of positive mental hygiene in order to give proper consideration to these new advances. Why create a new discipline in the general science of education merely because of new discoveries and ideas? New facts in general psychology, when

[1] *Mental Hygiene of the School Child*, by Percival M. Symonds. New York: The Macmillan Company, 1934.

applied with an educational purpose, belong to educational psychology.

Examination of the ideas that Symonds and others would like to term positive mental hygiene reveals that many of them are good old educational ideas that have been taught since time immemorial. They appeared in the writings of many of the philosophers of the Middle Ages; were strongly emphasized in the works of Comenius, Pestalozzi, and Froebel; and have been made much of by Burnham in his *The Normal Mind*. It is our observation that these ideas are being taught in our state teachers colleges, scattered throughout the various courses, though perhaps without as much emphasis in some cases as we should like to see.

Relative to the discussion of positive versus negative mental hygiene, one should bear in mind that formal instruction in ways of behaving and thinking is generally of little value. What is more effective is good example, the life in and the spirit of the school and the home. Equally important is a deep feeling for moral values. These comments apply with equl force to the prospective teacher and those responsible for her professional training.

What is being done along mental-hygiene lines elsewhere? What do we find in other teacher-training institutions outside of the state?

Montclair State Teachers College, in New Jersey, is outstanding in its work. The teaching of educational psychology and tests is based largely on the broader concepts of the field of educational psychology to which we have referred. It is closely integrated with observation of human nature as studied in the children of its practice or training school through the medium of a mental-hygiene clinic. The staff of the clinic are the instructors in educational psychology and tests. Their work is not limited to teaching, but extends to helping the student teacher to a better understanding and improvement of her own personality.

Newark State Teachers College is also doing notable work along mental-hygiene lines. It gives a course called "Mental Hygiene," but its mental-hygiene work is in the main concerned with the development of the personality of the student teacher. At the present time this course is given in two

sections—one of two hours a week, for ten weeks, prior to the practice experience of the students; the other of from one to two hours a week, after the practice work. It is required in the general elementary, kindergarten, and primary departments, but is not required of students either in industrial arts or the fine arts.

In New York State the department of education provides a full-time consultant in psychiatry for their teacher-training institutions. This psychiatrist travels throughout the state, lecturing in mental hygiene at the various schools, and giving psychiatric service to individual students referred to him by the colleges.

Dr. Averill of Worcester made a study for the White House Conference of the teaching of mental hygiene in the years 1929 and 1930. His main conclusions may be stated briefly as follows:

1. The total enrollment of students in the schools included in this study for the year 1929–30 was 135,414. A few institutions failed to state their enrollment, so the actual figure would be considerably in excess of this. Summer-school registrants were included in a number of cases. Thus, one large institution reported an enrollment during the four quarters of 5,000, while several others ran to about 2,500.

2. Students to the number of 29,231 were reported in those 27 schools which had courses in mental hygiene; 106,183 students were enrolled in schools that had no specific courses in that subject. The former comprised 25 per cent, the latter 78 per cent, of all students enrolled in 181 institutions. Less than 10 per cent of those in the first group had work in mental hygiene, the actual number of teachers-in-training in 1929–30 who were studying mental hygiene in a regular course being 2,104.

3. Less than 15 per cent of the teacher-training institutions offered either elective or required courses in mental hygiene, although in the remaining 85 per cent of these institutions a total of 211 courses devote some distinct attention to the subject.

4. Most schools that offered mental hygiene placed it in either the third or the fourth year.

5. The typical teacher of mental hygiene in 127 institutions

had a master's degree, had been a teacher of psychology for about ten years, and had had at least a year's experience—but not much more—in some phase of social work other than classroom teaching.

6. Two-thirds of the courses offered in mental hygiene placed their fundamental emphasis upon childhood adjustment and its problems, as distinct from student or general adult adjustment.

7. There was considerable lack of correspondence in the content of the 27 courses. In part, the divergence was due to the lack of accepted terminology, and in part to the tendency of some who answered the questionnaire to enumerate specific aspects of a general problem which others did not so analyze. All in all, the problems covered in the aggregate appeared not inconsistent with the outstanding aims that good courses in mental hygiene should exemplify.

8. In addition to lack of agreement in the matter of content of the mental-hygiene course, there was even less correspondence in the matter of the time devoted to such aspects of the subject as were included. In the main it appeared to be the case that one-third of the emphasis in these courses was directly upon child adjustment, another one-third indirectly upon the same problem, while the remaining third was upon such social and general adult problems as insanity, mental disease, feeblemindedness, and adult maladjustment. This would seem to be a defensible allocation of time and emphasis.

9. An increasing amount of attention in the training institutions was being devoted to such specialized aspects of mental hygiene as mental testing, problems of retardation and of acceleration, maladjustment, and the like. It is significant that 131 courses in these and related subjects were offered in the schools that reported.

10. Schools that had no specific course in mental hygiene were, in a large number of cases, providing their students some training in the subject in connection with other courses. Often this incidental work was brief and inadequate; sometimes, on the other hand, it was quite comprehensive, and was found to dominate the entire point of view of the course. The mental-hygiene reference and content of these related courses varied greatly among the several schools.

11. The facilities represented by child guidance or psychiatric clinics are still in the main not available to those in training for the profession of teaching. For most training institutions still, the mental-hygiene work must be limited to reading, classroom discussion, study of second-hand case material, lectures, and infrequent field trips—for example, to a state school for the feebleminded.

12. The services of a psychiatrist were available in but few schools for consultation with students who might have profited greatly from an opportunity to iron out their personal difficulties of attitude and adjustment under expert direction.

THE SITUATION IN MASSACHUSETTS

It is difficult to make any general statements about the work of the Massachusetts state teachers colleges from our own particular point of view. The reason is that many of them are in a state of transition from non-degree to degree-awarding institutions.

There is variation in what is taught in the courses entitled educational psychology, both elementary and advanced. The same is true in regard to the teaching of educational tests and the more practical courses in education. There is more uniformity in the teaching of physical education. A degree of this is desirable. We note some teaching of health education in the practical courses in education as well as in physical education and in courses in hygiene. In some schools considerable mental hygiene is taught, and in no school is it omitted entirely. On the other hand, much more could with profit be offered in these schools. In one or two the educational psychology taught is of as high a grade as that offered by departments of psychology in colleges of liberal arts. The same may be said of educational and mental tests. In only one of the colleges are sufficient laboratory facilities provided. In none did we find any attempt to utilize for teaching purposes the human material in the practice or training schools to the extent noted at Montclair. In occasional instances studies of individual children have been made, but only one school takes advantage of the facilities of a local child-guidance clinic.

A certain amount of overlapping and duplication in teaching was noted. This would seem to be a profitable field for

investigation on the part of those interested in the curriculum, as, with the growing inclination to offer more instruction in a wider number of subjects, there is a tendency to overload the student teacher with academic work. Almost every one interviewed stated that it would be advisable to reduce the number of courses or to amalgamate many of the subjects taught in order to cut down duplication and overlapping. A manual of instruction for the teachers of physical education, prescribed by the state department of education, includes a few hours devoted to the topic of mental hygiene. This arrangement should be continued only where instruction in mental hygiene is not given in other courses. This does not mean, however, that there should be any lessening of interest on the part of those teaching physical education in presenting a broad view of human nature in their daily teaching.

While we find that the medical service provided the colleges is satisfactory, it could be augmented in the direction already taken at the Newark State Teachers College. Here the physician gives a considerable portion of her professional time to the medical care of the student teacher, and she works cooperatively with other members of the faculty directly concerned.

Our observations of the training or practice schools were restricted almost entirely to investigating their possibilities for the study of child nature. The syllabus of courses in education for the four-year elementary course recognizes the value of observation paralleling class work. We find, however, that where this has been tried, it has not worked out very well. Many of the topics taken up in class are not adapted to the kind of observation that is carried out at the practice or training schools. Every such school visited gave a distinct impression of offering a wealth of material for the study of child nature, both normal and abnormal. Sitting before a class, one could readily see that there were many children with problems, both physical and mental. Some schools had more, others less. In many instances these problems were not recognized by the classroom teacher. When they were recognized, the teachers stated that for many children very little could be done either because the home could or would not coöperate, or because the local school system, of which the

training or practice school is a part, or the community itself did not provide facilities.

The faculty-adviser system in the state teachers colleges of Massachusetts operates perhaps as well or as poorly as elsewhere. The main difficulties are the small amount of time that the advisers have to give to counseling, the lack of training in many instances, and in many others a lack of the type of personality that is essential to good counseling. Discipline is taken care of as well as elsewhere. The disciplinary function is a large part of the work of student-government bodies, and major infractions, which are infrequent, are taken care of by the president's office in coöperation with members of the faculty. Many instructors have stated that they would appreciate help in handling problem cases. The question has arisen as to how many disciplinary cases are deep-seated personality difficulties and not properly handled because of failure to recognize them. We are not able to answer this question, but experience elsewhere indicates that the number of such cases is quite large and merits special attention. The same is true of student teachers who do not present disciplinary problems, but whose failure of adjustment may be problems to themselves and to others.

One or two suggestions as to the selection of student teachers may be made. Everything should be done to secure the most capable group of entering students. However, the process of selection should be made an opportunity to appraise the personalities of applicants from the point of view not only of intellectual capacity, but also of emotional make-up. In other words, entrance inquiry should afford an opportunity for study of the whole personality. In our opinion, the attitude of the college should be, within reason, not to make admission too difficult, but to contribute to an upbuilding and development of personality. This surely should be the policy of tax-supported institutions.

On the whole the student body does not present serious disciplinary problems. The attitude of the students toward their work seems to be for the most part that of students seriously interested in preparing for their professional careers.

RECOMMENDATIONS

Our recommendations apply chiefly to the teaching of educational psychology, testing, and the practical courses in education, though personnel policies and practices are necessarily to some extent involved.

As we have already stated, the courses in educational psychology should be modified to contain the new material which is now occupying an important place in that field. The point of view taken by Trow in his book, *Educational Psychology,*[1] and by Pressey, in *Psychology and the New Education,*[2] are good examples of what we have in mind. Such courses should emphasize the influence on the learning process of motivation, of the emotions, of personality, and of physical and mental growth. In addition, there should be equal opportunities in all of the colleges for laboratory experimentation. Testing should be given a larger place in the curriculum than is now suggested in the syllabus of courses in education for the four-year elementary course. The diagnosing of group and individual weaknesses in subject matter and the provision of remedial instruction is assuming great importance in teaching. Also, there should be greater uniformity of teaching in testing, but only in rare instances should there be any encouragement to the training of student teachers to become clinical testers. Instructors in educational psychology and testing and those teaching the practical aspects of education should be encouraged to confer more frequently in order to avoid overlapping and duplication both in the local institution and in the state teachers colleges at large. Their instruction should not lead to a confusion in thinking such as conflicting ideas sometimes cause in the minds of the inexperienced student teacher. At the same time, we do not encourage a dogmatic attitude which gives expression to one point of view only in regard to psychological problems; but rather where there are differences of opinion, we advocate that these differences be brought out by all of the instructors and the students be allowed to form their own conclusions. Further-

[1] *Educational Psychology,* by William Clark Trow. Boston: Houghton Mifflin Company, 1931.

[2] *Psychology and the New Education,* by Sidney Leavitt Pressey. New York: Harper and Brothers, 1933.

more, the need of paralleling classroom work with observation in the practice or training school should always be kept in mind.

The best way to accomplish this, in our opinion, is to establish a clinical agency in connection with the practice or training school. This agency would not only be beneficial to the student teachers, but would be of distinct service to the children in the grades.

In a preliminary report, presented a year ago, we recommended an agency organized along the lines of a child-guidance clinic. During the past year this idea has been modified. We now have in mind a clinic (we cannot find a better word) which would provide what might be called educational guidance or educational hygiene. We use either of these terms to describe that kind of service which our educational and clinical psychologists have been so ably providing in the form of tests and similar procedures, and the kind of service which mental-hygienists have been offering through their child-guidance clinics. An educational agency which conceives of the mental health of the child purely in terms of problems or of emotional factors is too one-sided and can offer only limited service to education. In our plan, every child in the grades would be studied. No question would be raised as to whether a boy or girl were a normal or a problem child. For instance, here is a child whom the teachers would like to understand better in order to modify the curriculum for his particular needs. If, as he goes through the grades, an educational difficulty is found, such as in reading, writing, or arithmetic, the clinic would be consulted to learn where the problem lies, how it probably arose, and what should be done about it. The problem may be emotional in origin, or the result of some intellectual defeat or faulty instruction on the part of a teacher or of unwholesome conditions in the home. This clinic would be especially adapted to the needs of education, would amalgamate and integrate within itself all of the clinical and testing aids which physicians, psychiatrists, psychologists, social workers, and educators have discovered and developed. A further advantage would be that all of these services would be performed by a single agency and that the possible stigma of abnormality would be avoided.

Such an agency might be called a bureau of educational guidance or educational hygiene, or a psycho-educational clinic. We recommend that it be headed by a psychiatrist with special training in child guidance and an educational psychologist, especially trained in clinical testing procedures. There should also be a psychiatric social worker or a visiting teacher to make contacts outside of the school and to assist in the routine of the clinic.

Assuming that such an agency became a reality, student teachers in their third and fourth years could actually participate in its routine under supervision. Second-year students could attend staff conferences and observe the workings of the clinic. Of course, lectures should be given to parallel observation. It would seem best that this bureau or clinic should first be tried out in one college. If it proved a success, the others would naturally follow suit.

We do not recommend as a substitute plan the utilization of a child-guidance clinic which may happen to operate conveniently near, but, on the other hand, we would not discourage this where it is now in effect. Child-guidance clinics function chiefly for the purpose of adjusting maladjusted boys and girls, and, in our opinion, are not particularly adapted for the special purposes of education. They do well as far as they go, but it is our opinion that the educational system will not be satisfied except by a clinical agency which has the particular needs of education always in mind and which can offer a special educational atmosphere.

In addition, we should like to see a course in psychology in the first year in all schools, for a certain amount of background in psychology should precede participation in the training or practice schools. There should also be a course in social psychology in some later year which would give the student some insight into mass psychology and its problems.

Some people object to adding more psychology and education to the curriculum. They believe that there is already too much emphasis on the teaching of psychology and education, especially when we include the academic courses such as history, mathematics, and literature, in which considerable method is given. They feel there are too few of the cultural courses. This may be true, but it should be remembered that

psychology as a science has cultural value. If the courses in psychology and education were modified along the lines we have recommended, much of the new material would have cultural as well as professional value.

Of course, our recommendations are made with the hope that the curriculum as a whole would be kept in mind and no overloading of student time permitted. In our opinion, there need be no such overloading if duplication and overlapping are reduced to a minimum, as has already been recommended.

With such a clinical agency connected with a practice or training school, its personnel could be utilized for the development of student-teacher personality. Without it, there is little to suggest. The faculty-adviser system may be improved by seeing to it that those faculty members who are doing most of the counseling are relieved of some of their teaching and that they are encouraged to take special training along the lines of educational counseling.

The curriculum should include a short course on the exceptional child. In the event that a college should finally have a bureau or clinic connected with its practice or training school, such a course might be eliminated. There should also be a course specifically called "Mental Hygiene," which would cover such topics as mental disease and disorder, mental defect, epilepsy, delinquency, and crime. This course should also treat the topic of the problem child, but care should be taken that there be no serious overlapping between this course and that dealing with the exceptional child. It should be kept clearly in mind that the chief object of these two courses is to acquaint the prospective teacher with this field rather than to give her a special technique for handling the individual case. In other words, she should learn *what* and *why*, but not *how*, except in so far as to know when, where, and how to refer children for help. The prospective teacher should realize that the educational process is becoming so complicated that she alone cannot do a satisfactory teaching job without educational aids outside of the classroom.

For the two state teachers colleges which are now training the bulk of teachers for the more rural areas of the state, the clinical adjunct to the practice or training school might be more practically conceived as a community clinic to be organ-

ized and administered under the joint auspices of the state department of mental diseases and the state department of education and to serve not only the colleges in question, but the regions of the state in which they are located. At the present time, the whole Cape and the area around North Adams have relatively few facilities to serve the needs either of the training or practice schools or of the community as a whole. The Massachusetts Society for Mental Hygiene frequently receives requests for such service, and there is little that it can offer.

Our discussion in the main holds also for the junior and senior high-school courses. The curriculum should provide a short course on the psychology of adolescence for students enrolled in these courses. At the present time the course for special-class teachers at Salem is utilizing clinical facilities to a larger extent than we find in the colleges generally; these students are given considerable material with a mental-hygiene connotation in their class work. Nevertheless, this course would receive much benefit from having a clinical agency in the training or practice school at Salem. The same may be said of the course in household arts at Framingham. Those preparing for this profession would benefit greatly from the intimate study of child nature which a bureau or clinic would provide. The recommendations in general apply with less force to the special courses which certain of the colleges offer in industrial arts, music, and commercial science.

Undoubtedly some of our recommendations may be difficult to carry out at once because of the present economic situation. We suggest, however, that they be studied and considered, and if acceptable, they might be included in the plans of five or ten years from now, when we all hope that the nation will have emerged definitely from the depression. The recommendations which do not require an expensive outlay of funds might well be put into effect in the near future.

MENTAL DISEASE IN NEW YORK STATE ACCORDING TO NATIVITY AND PARENTAGE

BENJAMIN MALZBERG, PH.D.
New York State Department of Mental Hygiene

THE part that should be attributed to the foreign born as a contributing factor in mental disease in New York State has been a subject of study for many years. Even in the early decades of the nineteenth century, important state legislative committees were interested in the reasons for the constant growth of the insane population and ascribed it in part to the special rôle of New York State as a receiving station for immigrants. Significant changes in the tides of immigration have taken place since 1914, and the newer trends will doubtless remain permanent, owing to the force of legislative enactment. Nevertheless, the composition of the population of New York State still reflects the part played by immigration. Thus, according to the Federal census of April 1, 1930, the white population of the United States consisted of 87.7 per cent of native and 12.3 per cent of foreign born, whereas the corresponding percentages in the state of New York were 73.7 and 26.3, respectively. Furthermore, natives of native parentage included 64.4 per cent of the white population of the country, but only 36.8 per cent of the white population of New York State. Natives of foreign and mixed parentage were in corresponding excess in New York State.

Definite changes have taken place in the composition of the population of New York State since 1910. In the latter year the native born constituted 69.6 per cent of the total white population. They increased to 72.6 per cent in 1920, and reached 73.7 per cent in 1930. The foreign born, on the contrary, decreased from 30.4 per cent in 1910 to 27.4 per cent in 1920, and to 26.3 per cent in 1930. The change was most marked among the group described as natives of mixed parentage—that is, with one parent native and the other foreign born. This class represented 25.0 per cent of the

white population in 1910, and 27.6 per cent in 1930. Natives of foreign parentage increased from 8.5 to 9.3 per cent in the two decades. Natives of native parentage increased from 36.0 to 36.8 per cent.

In analyzing the growth of the state-hospital population in its annual reports, the State Hospital Commission (now the Department of Mental Hygiene) has called attention repeatedly to the presence of the foreign born in disproportionate numbers. The problem was considered of such importance that in 1912 the Commission undertook a special study of the foreign-born insane, as a result of which it was concluded that the frequency of insanity among the latter exceeded that of the native white in the ratio of 2.19 to 1.[1] The problem of differential rates of mental disease in the several nativity groups has continued to receive attention since that date, the best known studies being those conducted under the auspices of the Congressional Committee on Immigration and Naturalization.[2] These studies also concluded that the foreign born contribute insane at a rate twice that of the whole population.

The present writer has elsewhere discussed in some detail the studies bearing on the subject of immigration and insanity,[3] and therefore does not believe it necessary to repeat the critical analyses of their methods and results. It appears of greater utility to present new data, carefully gathered, and capable of supplying answers to many of the questions concerning the relations of nativity to mental disease. In view of the newer population trends, such an analysis assumes added significance.

The data utilized in this study consist of all white patients with mental disease received in institutions, public or private, for the treatment of mental disease, in the state of New York during the three fiscal years ended June 30, 1931. There were 26,765 such admissions during the three years,

[1] *New York State Hospital Bulletin*, Special Immigration Number, April, 1912. p. 19.

[2] Hearing before the Committee on Immigration and Naturalization, House of Representatives, Sixty-seventh Congress, Third Session, November 21, 1922. (Serial 7-C.) Also Hearing before the Committee on Immigration, Sixty-eighth Congress, First Session, March 8, 1924. (Serial 5-A.)

[3] See "Mental Disease and the Melting Pot," by Benjamin Malzberg. *Journal of Nervous and Mental Disease*, Vol. 72, pp. 379–95, October, 1930.

of whom 15,704, or 58.7 per cent, were native born and 10,987, or 41.0 per cent, foreign born; nativity was unascertained in 74 cases. As the latter total is of relatively slight numerical significance, no account has been taken of it in adjusting the rates of first admission.

Average annual rates of first admission are shown for the several nativity groups in Table 1.

TABLE 1.—NUMBER OF WHITE FIRST ADMISSIONS TO ALL INSTITUTIONS FOR MENTAL DISEASE IN NEW YORK STATE FROM 1929 TO 1931, CLASSIFIED BY NATIVITY AND PARENTAGE, WITH AVERAGE ANNUAL RATES OF FIRST ADMISSIONS PER 100,000 POPULATION

	Number			*Average annual rate per 100,000 population*		
	Males	Females	Total	Males	Females	Total
Native born....	8,677	7,027	15,704	65.4±0.8	52.1±0.7	58.7±0.5
Native of native parents.....	3,982	3,195	7,177	59.6±1.1	47.8±1.0	53.7±0.7
Native of foreign parents.....	3,397	2,760	6,157	68.8±1.4	54.3±1.2	61.5±0.9
Native of mixed parents.....	1,298	1,072	2,370	78.3±2.5	61.8±2.2	70.1±1.7
Foreign born....	6,204	4,783	10,987	125.5±1.9	104.0±1.8	115.1±1.3

The native born had an average annual rate of first admissions of 58.7 per 100,000 population. The foreign born had a rate of 115.1, which exceeded that of the natives in the ratio of 2.0 to 1. The native born may be further analyzed according to parentage. Those of native parentage had a rate of 53.7. The rates increased among natives of foreign parentage, and natives of mixed parentage, these two groups having rates of 61.5 and 70.1, respectively. Among males, the native and foreign born had rates of 65.4 and 125.5, respectively, the latter being in excess in the ratio of 1.9 to 1. Natives of native parentage had a minimum rate of 59.6. There is a similar trend among females, among whom native and foreign born had rates of 52.1 and 104.0, respectively, the latter being in excess in the ratio of 2.0 to 1. Natives of native parentage had a minimum rate of 47.8.

It appears, therefore, that mental disease is twice as prevalent among the foreign born as among the native born, and that the rate is a minimum among natives of native parentage. Some writers, notably Dr. Harry H. Laughlin, of the Eugenics

Record Office, have concluded that such crude rates indicate biological differences. Such a conclusion implicitly assumes that the foreign and native stocks are alike in every respect except place of birth, and that the differences in rates of first admissions may therefore be properly ascribed to the influence of nativity alone. However, it is important to note that there are fundamental demographic differences among the two groups, the most important being with respect to age. The foreign whites are considerably older than the native born, their average ages on April 1, 1930, being 42.4 and 26.9 years, respectively. Natives of foreign and mixed parentage were younger than natives of native parentage. The age distributions are given in detail, by per cents, in Table 2. As is well known, there is a correlation between age and rate of mental disease; the rate is lowest in the youngest age groups and reaches a maximum in old age. Reference to Table 2 will show that the foreign white have low representations under twenty years of age, but high proportions in the middle years of life. The native born, on the contrary, have high percentages in age groups under twenty years, and decreasing percentages at the higher age levels. This obviously results in an unequal weighting of the specific age rates of mental disease in the two nativity groups.

We may consider the factor of age by reference to Table 3 (page 641), in which are given rates of first admissions for males and females according to age and nativity. It is clear that the rates are a minimum in each group in the youngest age intervals and that they rise to maxima in old age. No significance need be attached to the rates for those under fifteen years of age, nor to some of the rates at seventy-five years and over, as these cannot be considered reliable. Among native males, the rates rise from 42.8 at fifteen to nineteen years to 371.5 at eighty years and over. Among the foreign-born males the rates rise from 73.4 to a maximum of 518.5. With but one exception, the rate of the foreign born exceeds that of the natives in each interval. The excess is relatively greatest at the extremes of the age distribution, but owing to the variability of these rates, the resulting ratios cannot be considered reliable. In the remaining intervals the maxi-

TABLE 2.—AGE DISTRIBUTION, IN PER CENTS, OF WHITE POPULATION OF NEW YORK STATE, APRIL 1, 1930, CLASSIFIED ACCORDING TO NATIVITY AND PARENTAGE

AGE (YEARS)	NATIVE WHITE												FOREIGN WHITE		
	TOTAL			*Of native parents*			*Of foreign parents*			*Of mixed parents*					
	Males	Females	Total	Males	Females	Total	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 5	10.8	10.3	10.6	11.3	10.9	11.1	9.1	8.5	8.8	14.0	12.8	13.4	0.3	0.3	0.3
5–9	11.6	11.1	11.4	11.1	10.7	10.9	11.9	11.3	11.6	13.1	12.1	12.6	1.0	1.0	1.0
10–14	11.6	11.1	11.3	9.8	9.6	9.7	14.0	13.3	13.6	11.5	10.7	11.0	1.1	1.2	1.2
15–19	10.7	10.6	10.6	8.7	8.6	8.7	13.7	13.5	13.6	9.8	9.3	9.5	2.6	3.1	2.8
20–24	9.7	9.9	9.8	8.7	9.0	8.8	11.4	11.6	11.6	8.6	8.5	8.6	5.9	7.3	6.6
25–29	8.2	8.3	8.3	8.3	8.4	8.3	8.2	8.4	8.3	7.5	7.9	7.7	9.7	10.5	10.1
30–34	7.4	7.5	7.4	7.7	7.8	7.8	7.0	7.0	7.0	7.0	7.6	7.3	11.4	11.4	11.4
35–39	6.7	6.7	6.7	7.3	7.3	7.3	5.9	5.8	5.8	6.6	7.2	6.9	13.7	12.9	13.3
40–44	5.4	5.4	5.4	6.2	6.1	6.1	4.2	4.2	4.2	5.6	6.0	5.8	13.6	11.9	12.8
45–49	4.4	4.5	4.4	5.2	5.2	5.2	3.3	3.4	3.4	4.7	5.1	4.9	11.7	10.5	11.1
50–54	3.9	4.0	3.9	4.4	4.4	4.4	3.3	3.3	3.2	4.0	4.3	4.2	9.3	8.7	9.0
55–59	3.1	3.2	3.2	3.4	3.4	3.4	2.7	3.0	2.8	3.0	3.1	3.1	6.6	6.6	6.6
60–64	2.4	2.6	2.5	2.7	2.8	2.7	2.2	2.5	2.4	2.0	2.2	2.1	5.3	5.6	5.4
65–69	1.8	1.9	1.9	2.0	2.1	2.1	1.6	1.9	1.7	1.2	1.4	1.3	3.8	4.0	3.9
70–74	1.2	1.4	1.3	1.5	1.6	1.6	1.1	1.3	1.2	0.8	0.9	0.8	2.3	2.5	2.4
75–79	0.7	0.8	0.7	0.9	1.0	1.0	0.4	0.6	0.5	0.4	0.4	0.4	1.1	1.3	1.2
80–84	0.3	0.4	0.3	0.4	0.6	0.5	0.1	0.2	0.2	0.1	0.2	0.2	0.5	0.7	0.6
85 and over	0.1	0.2	0.2	0.2	0.3	0.3	*	0.1	0.1	0.1	0.1	0.1	0.2	0.4	0.3
Unascertained	0.1	0.1	0.1	0.1	0.1	0.1	*	0.1	*	*	0.1	0.1	0.1	0.1	0.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Average age	26.5	27.3	26.9	28.1	28.7	28.4	24.8	25.8	25.3	24.8	26.1	25.5	42.5	42.3	42.4
Standard deviation	18.8	19.2	19.0	19.7	20.0	19.9	17.6	18.2	17.9	18.4	18.7	18.6	14.9	15.7	15.3

* Less than 0.05 per cent.

mum excess is not above 30 per cent, and in many cases the excess is less than 10 per cent. The lowest specific rates are shown by natives of native parentage, among whom the rates rose from 33.0 at fifteen to nineteen years to 285.7 at eighty years and over. The rates among natives of foreign parentage exceed those of natives of native parentage, but are, on the whole, significantly less than those of the foreign born, exceptions to this trend occurring between fifty-five and sixty-nine years. Natives of mixed parentage, on the contrary, have the highest specific rates, and exceed those of the foreign born in each age interval, beginning with twenty-five years.

Very similar contrasts are shown by the several nativity groups among females, though the rates are lower than those among males.

The differences in specific age rates of first admission may be combined with the facts of differential age distribution to give summary rates from which differences due to sex and age proportions have been eliminated. The rates, standardized by age and sex, are given in Table 12 (page 657). The population used as the standard was that of the state of New York, aged fifteen years and over on April 1, 1930, as shown by the Federal census.

The native born had a standardized rate of 91.8 per 100,000 population. The foreign born had a corresponding rate of 108.8, which exceeded that of the natives by 19 per cent. On the basis of crude rates, the foreign born had exceeded the native by 96 per cent. Hence age alone sufficed to account for by far the greater part of the difference. Natives of native parentage had the lowest standardized rate, namely 75.2. Natives of foreign parentage followed with a rate of 100.9, which exceeded that of natives of native parentage by 34 per cent. The highest rate occurred among natives of mixed parentage, who had a rate in excess of natives of native parentage and of foreign parentage by 57 and 17 per cent, respectively. It is significant to note that standardization increased the disparity between the rates of natives of native parentage and those of foreign or mixed parentage. Furthermore, the latter group had a rate in excess of that of the foreign born by 8 per cent.

TABLE 3.—AVERAGE ANNUAL RATES OF FIRST ADMISSIONS TO ALL INSTITUTIONS FOR MENTAL DISEASE IN NEW YORK STATE FROM 1929 TO 1931, CLASSIFIED ACCORDING TO SEX, NATIVITY, PARENTAGE, AND AGE

	MALES					FEMALES				
AGE (YEARS)	*Total native born*	*Native of native parents*	*Native of foreign parents*	*Native of mixed parents*	*Foreign born*	*Total native born*	*Native of native parents*	*Native of foreign parents*	*Native of mixed parents*	*Foreign born*
Under 15	2.2	1.7	2.7	2.4	0.8	1.5	1.2	1.6	2.1	1.7
15–19	42.8	33.0	49.1	47.9	73.4	29.8	22.2	35.0	31.1	45.4
20–24	79.4	66.6	88.4	85.4	100.2	50.7	40.2	57.6	57.2	64.1
25–29	79.8	69.1	82.4	105.1	90.9	58.3	53.5	59.1	65.9	79.1
30–34	84.5	73.5	86.2	103.0	101.2	72.1	63.9	73.5	90.6	84.0
35–39	97.8	75.8	106.1	141.3	111.5	75.0	64.3	85.0	88.1	93.7
40–44	96.5	80.7	106.1	127.3	122.2	90.5	85.9	86.0	99.6	99.5
45–49	110.6	85.2	132.3	154.5	115.0	89.1	73.1	106.5	97.9	94.7
50–54	114.0	93.3	126.7	149.0	134.0	101.1	80.3	117.8	129.6	100.9
55–59	136.4	110.8	147.0	176.8	126.4	100.9	77.1	117.2	135.3	108.9
60–64	153.2	121.4	185.9	174.3	162.2	108.6	87.2	114.5	162.8	119.6
65–69	194.5	150.0	216.5	270.0	202.8	136.2	103.7	155.6	184.8	163.2
70–74	275.0	224.3	285.2	311.7	286.7	188.1	143.3	215.0	229.8	252.9
75–79	363.8	278.3	368.6	678.5	415.1	252.5	301.3	267.7	362.9	358.6
80 and over	371.5	285.7	424.6	534.0	518.5	317.9	226.1	390.1	783.3	515.3

Among males the native born and the foreign born had standardized rates of 103.2 and 120.1, respectively, the latter being in excess by 16 per cent. The corresponding excess on the basis of crude rates was 92 per cent. The lowest standardized rate, 83.7, occurred among natives of native parentage. The rate of the foreign born was in excess of the latter by 43 per cent, though this is a material reduction from the excess of 111 per cent indicated by the crude rates. The highest standardized rate, 134.3, occurred among natives of mixed parentage, this rate exceeding that of natives of native parentage by 60 per cent. The former also exceeded the foreign-born rate by 12 per cent, a difference that is barely significant. Thus, whereas standardization lowered the rate of first admissions among the foreign born, it increased those of the native-born groups, the greatest relative increases occurring among those of foreign or mixed parentage.

In the case of the females, the native born had a standardized rate of 79.7, compared with 95.7 among the foreign born, the latter being in excess by 20 per cent, instead of the 100 per cent indicated by the crude rates. Natives of native parentage had the lowest rate, 66.3; natives of mixed parentage had the highest rate, 99.3. The latter, however, does not differ significantly from the rate of either the natives of foreign parentage or the foreign born. In the case of the females, standardization again increased the disparity between the rate of natives of native parentage and those of the other groups of native born.

We may also note that standardization increased the relative excess of the male over the female rates.

It is evident from the preceding results that even after age differences have been eliminated, the foreign born still have a higher rate of first admission than the native born, though the excess is much less than that derived solely on the basis of crude rates. It is also of importance to note, however, that within one generation there has been a significant decrease in the rate of the foreign group, natives of foreign parentage having a lower rate than the foreign born. If we assume that the two groups are of the same racial origin, then the difference can only be attributed to environ-

mental changes affecting those of the second generation, especially in their habits of life.

In the following sections rates of first admissions, according to nativity and parentage, will be considered in connection with several of the more important groups of psychoses.

Senile Psychoses.—There were 2,457 white first admissions with senile psychoses to all institutions for mental disease in New York State during the three years ended June 30, 1931. Of these 1,289 were native and 1,151 foreign born. Nativity was unascertained in 17 cases. Average annual rates of first admission are given for the several nativity groups in Table 4.

TABLE 4.—NUMBER OF FIRST ADMISSIONS WITH SENILE PSYCHOSES, TO ALL INSTITUTIONS FOR MENTAL DISEASE IN NEW YORK STATE FROM 1929 TO 1931, CLASSIFIED BY NATIVITY AND PARENTAGE, WITH AVERAGE ANNUAL RATES OF FIRST ADMISSIONS PER 100,000 POPULATION

	Number			*Average annual rate per 100,000 population*		
	Males	Females	Total	Males	Females	Total
Native born	566	723	1,289	4.3±0.2	5.4±0.2	4.8±0.2
Native of native parents	321	350	671	4.8±0.3	5.2±0.3	5.0±0.2
Native of foreign parents	182	280	462	3.7±0.3	5.5±0.4	4.6±0.3
Native of mixed parents	63	93	166	3.8±0.6	5.4±0.7	4.9±0.4
Foreign born ..	462	689	1,151	9.3±0.5	15.0±0.7	12.1±0.4

The native born had an average annual rate of 4.8 per 100,000 population, compared with a rate of 12.1 among the foreign born. The latter is in excess in the ratio of 2.5 to 1. Natives of native parentage had a rate of 5.0. This exceeded the rates of natives of foreign parentage, and of natives of mixed parentage, the latter having rates of 4.6 and 4.9, respectively.

Among males, the native and the foreign born had rates of 4.3 and 9.3, respectively, the latter being in excess in the ratio of 2.2 to 1. Natives of foreign parentage and natives of mixed parentage had rates of 3.7 and 3.8, respectively. These may be compared with a rate of 4.8 among natives of native parentage. Among females, the rate of the foreign born, 15.0, exceeded that of the natives, 5.4, in the ratio

of 2.8 to 1. Natives of native parentage had the lowest rate, 5.2, but it does not differ significantly from the rates of natives of foreign or mixed parentage.

These rates are clearly influenced, however, by the varying proportions of older persons in the several nativity groups, as was indicated in Table 2. It is, therefore, necessary to eliminate the differences due to age. The resulting standardized rates are shown in Table 12, the standard population being that of the state of New York, aged forty-five years and over, on April 1, 1930.

The native born had a standardized rate of 24.1 per 100,000 population. The foreign born had a rate of 32.2. The latter rate is in excess by 34 per cent. This is in marked contrast to the excess of 152 per cent indicated on the basis of crude rates. The lowest standardized rate occurred among natives of native parentage. The highest rate occurred among natives of mixed parentage, though this rate does not differ significantly from that of the foreign born.

Among males the standardized rates were 21.7 and 25.0 for natives and foreign born, respectively, the latter amounting to an excess of only 15 per cent, which is not statistically significant. This represents a marked decrease from the excess of 116 per cent indicated by the crude rates. In the case of the females, the foreign born had a standardized rate of 33.5, compared with a rate of 22.7 among the native born. The former is in excess by 48 per cent. Among both males and females, the lowest standardized rates prevailed among natives of native parentage; the highest, among natives of mixed parentage. The rates among the latter group do not differ significantly from those of natives of foreign parentage and from those of the foreign born. But it is important to note the contrast with the crude rates, according to which the foreign born had higher rates than either of the native groups of foreign or mixed parentage. Age consequently concealed the true order of differences. Similarly it is important to note that with the elimination of age differences, it becomes apparent that natives of native parentage have a lower rate than natives of foreign or mixed parentage, reversing the order based upon crude rates.

Psychoses with Cerebral Arteriosclerosis.—During the

three years ended June 30, 1931, there were 3,698 white first admissions with psychoses with cerebral arteriosclerosis to all institutions for mental disease in New York State. Of these 1,945 were native and 1,741 foreign born. Nativity was unascertained in 12 cases. The average annual rates of first admissions are shown in Table 5.

TABLE 5.—NUMBER OF FIRST ADMISSIONS WITH PSYCHOSES WITH CEREBRAL ARTERIOSCLEROSIS, TO ALL INSTITUTIONS FOR MENTAL DISEASE IN NEW YORK STATE FROM 1929 TO 1931, CLASSIFIED BY NATIVITY AND PARENTAGE, WITH AVERAGE ANNUAL RATES OF FIRST ADMISSIONS PER 100,000 POPULATION

	Number			*Average annual rate per 100,000 population*		
	Males	Females	Total	Males	Females	Total
Native born ...	1,133	812	1,945	8.5±0.3	6.0±0.2	7.3±0.2
Native of native parents	593	397	990	8.9±0.4	5.9±0.3	7.4±0.3
Native of foreign parents	392	309	701	7.9±0.5	6.1±0.4	7.0±0.3
Native of mixed parents	148	106	254	9.0±0.9	6.1±0.7	7.5±0.6
Foreign born ..	972	769	1,741	19.7±0.7	16.7±0.7	18.2±0.5

The native born had an average annual rate of first admissions of 7.3, compared with a rate of 18.2 among the foreign born. The latter rate is in excess in the ratio of 2.5 to 1. The lowest rate, 7.0, occurred among natives of foreign parentage. Natives of native parentage and of mixed parentage had rates of 7.4 and 7.5, respectively, which do not differ significantly from each other. Among males the foreign-born group had a rate exceeding that of the native born in the ratio of 2.3 to 1. Among the native-born groups, those of foreign parentage had the lowest rate, those of mixed parentage the highest. Because of the relatively large probable errors, these rates do not differ significantly, however. Among females, the foreign-born rate exceeds that of the natives in the ratio of 2.8 to 1. The lowest rate is found among natives of native parentage, but this rate does not differ significantly from those of natives of foreign or mixed parentage.

As in the case of the senile psychoses, the preceding rates are influenced by the varying proportions of older individuals in the several nativity groups. We must, therefore, proceed

to an analysis of standardized rates of first admissions with psychoses with cerebral arteriosclerosis. As with the senile psychoses, the standard population is again that of the state of New York, aged forty-five years and over, on April 1, 1930. The standardized rates are given in Table 12.

The native born had a standardized rate of 37.4 per 100,000 population, compared with a rate of 46.0 among the foreign born, the latter being in excess by 23 per cent. The elimination of age differences thus accounted for almost the entire difference between the two groups, which, on the basis of crude rates, amounted to 149 per cent. The lowest rate, 30.1, occurred among natives of native parentage. This rate was exceeded significantly by the rates of natives of foreign parentage and natives of mixed parentage, the latter group having the maximum rate. This difference assumes added importance when the results are contrasted with the relative order based upon crude rates. The standardized rate of natives of mixed parentage does not differ significantly, however, from the rates of foreign born or of those with foreign parentage.

Among males, the native born had a rate of 44.8 compared with a rate of 50.1 among foreign born. This indicates a reduction from an excess of 132 per cent, based upon crude rates, to 12 per cent, based upon standardized rates, and the latter difference, furthermore, is not statistically significant. The lowest rate, 36.2, occurred among natives of native parentage. This rate is significantly lower than that among natives of foreign or mixed parentage. The latter group had a maximum rate of 60.5, but in view of its large probable error, it does not differ significantly from either that of the foreign born or natives of foreign parentage. Again, however, it is significant to note the relative order of the standardized rates among the native groups, in contrast with the order based upon the crude rates.

Among females, the native born and foreign born had standardized rates of 28.1 and 39.3, respectively, the latter being significantly in excess by 40 per cent. This may be compared with an excess of 178 per cent based upon crude rates. The natives of native parentage had a minimum rate of 22.6, and this differs significantly from the rates of 31.9 and 36.0

among natives of foreign and mixed parentage, respectively. The rate of the foreign born exceeds that of natives of foreign or mixed parentage, but the differences are not statistically significant.

General Paresis.—During the three years ended June 30, 1931, there were 2,524 white first admissions with general paresis to all institutions for mental disease in the state of New York. Of these 1,365 were native, and 1,153 foreign born. Nativity was unascertained in 6 cases. The average annual rates of first admissions are summarized in Table 6.

TABLE 6.—NUMBER OF FIRST ADMISSIONS WITH GENERAL PARESIS, TO ALL INSTITUTIONS FOR MENTAL DISEASE IN NEW YORK STATE FROM 1929 TO 1931, CLASSIFIED BY NATIVITY AND PARENTAGE, WITH AVERAGE ANNUAL RATES OF FIRST ADMISSIONS PER 100,000 POPULATION

	Number			*Average annual rate per 100,000 population*		
	Males	Females	Total	Males	Females	Total
Native born	1,047	318	1,365	7.9±0.3	2.4±0.2	5.1±0.2
Native of native parents	508	174	682	7.6±0.4	2.6±0.2	5.1±0.2
Native of foreign parents	373	95	468	7.6±0.4	1.9±0.2	4.7±0.2
Native of mixed parents	166	49	215	10.1±0.9	2.8±0.5	6.4±0.5
Foreign born	973	180	1,153	10.7±0.7	3.9±0.3	12.1±0.4

The native born had an average annual rate of 5.1, compared with a rate of 12.1 among the foreign born. The latter is in excess in the ratio of 2.4 to 1. The lowest rate occurred among natives of foreign parentage. Natives of mixed parentage had a higher rate than natives of native parentage. Owing to the large probable errors, these differences are not significant, however.

Among males, natives and foreign born had rates of 7.9 and 19.7, respectively, the latter being in excess in the ratio of 2.5 to 1. Natives of native and foreign parentage had the lowest rate, each having 7.6. Natives of mixed parentage had the highest rate among the native-born groups. Among females, the rate of the foreign born exceeded that of the native born in the ratio of 1.6 to 1. Natives of foreign parentage had the lowest rate.

Rates of first admission with general paresis are influ-

enced by the age composition of the population. The rates are highest in the mature decades of life and decrease in the older age intervals. This affects the foreign born adversely, since they have but a small proportion of aged. We proceed, therefore, to standardize the rates, using as the standard the population of the state of New York aged fifteen years and over on April 1, 1930. The resulting rates are shown in Table 12.

The native born had a standardized rate of 8.9 per 100,000 population, compared with a rate of 9.8 among the foreign born. The latter rate exceeds the former by only 10 per cent, compared with an excess of 137 per cent upon the basis of crude rates. With age differences eliminated, there is consequently no significant difference between the rates of the native born and the foreign born. The lowest standardized rate occurred among natives of native parentage, the highest among natives of mixed parentage. The latter rate, 10.6, exceeded that of the foreign born, though the difference does not meet the test of statistical significance.

Among males the crude rate of the foreign born exceeded that of the natives by 149 per cent. This, however, is due entirely to the age constitutions of the two groups. Standardization gave a rate of 14.2 for the native born, and a rate of 16.2 for the foreign born, an excess of only 14 per cent, which is not statistically significant. The lowest standardized rate occurred among the natives of native parentage. Their rate of 11.5 is significantly less than that of natives of foreign parentage or of natives of mixed parentage.

Among females standardization resulted in a lower rate for the foreign born than for the natives, the rates being 3.6 and 4.0, respectively, the difference not being significant, however. The rate of the foreign born was less than that of any of the native-born groups. The highest rate occurred among natives of mixed parentage. Natives of foreign parentage had a lower rate than natives of native parentage. Owing to the relatively large probable errors, none of the differences can be regarded as significant, however.

Alcoholic Psychoses.—There were 1,572 white first admissions with alcoholic psychoses during the three years ended June 30, 1931, of whom 859 were native and 711 foreign born.

Nativity was unascertained in two cases. The foreign born had an average annual rate of 7.4 per 100,000 population, which exceeded that of the native born in the ratio of 2.3 to 1. Natives of native parentage had lower rates than either natives of foreign or mixed parentage. The trends for males and females were similar to the preceding, though females had much lower rates than the males. The preceding rates are given in Table 7.

TABLE 7.—NUMBER OF FIRST ADMISSIONS WITH ALCOHOLIC PSYCHOSES, TO ALL INSTITUTIONS FOR MENTAL DISEASE IN NEW YORK STATE FROM 1929 TO 1931, CLASSIFIED BY NATIVITY AND PARENTAGE, WITH AVERAGE ANNUAL RATES OF FIRST ADMISSIONS PER 100,000 POPULATION

	Number			*Average annual rate per 100,000 population*		
	Males	Females	Total	Males	Females	Total
Native born	726	133	859	5.5±0.2	1.0±0.1	3.2±0.1
Native of native parents	297	58	355	4.4±0.3	0.9±0.1	2.7±0.2
Native of foreign parents	302	55	357	6.1±0.4	1.1±0.2	3.6±0.2
Native of mixed parents	127	20	147	7.7±0.8	1.2±0.3	4.3±0.4
Foreign born ...	609	102	711	12.3±0.6	2.2±0.3	7.4±0.3

To remove the influence of age, the rates have been standardized, the standard population being that of the state of New York, aged twenty years and over on April 1, 1930. These rates are given in Table 12.

The native born had a standardized rate of 6.3 per 100,000 population, compared with a rate of 6.7 among the foreign born, the latter rate being in excess by only 6 per cent, which does not indicate a reliable difference. On the basis of crude rates, the foreign born were in excess by 131 per cent. Age differences alone accounted for almost the entire difference in the incidence of alcoholic psychoses in the two groups. The lowest rate, 4.6, occurred among natives of native parentage. Natives of mixed parentage had the highest rate—8.5. Natives of foreign parentage also had a higher rate than the foreign born. Owing to the relatively large probable errors, the differences between the rates of natives of foreign or mixed parentage and that of the foreign born are not statistically significant. Nevertheless, it is important to note that with correction for differential age composition,

the rate of the foreign born is reduced to a level below that of the second generation of foreign born.

When analyzed according to sex, the standardized rates show results similar to the preceding. Among males, the natives and foreign born have standardized rates of 10.8 and 11.4, respectively. Among females, the corresponding rates were 1.9 and 2.1, respectively. These do not indicate any significant differences. Natives of native parentage have the lowest rates; natives of foreign or mixed parentage have the highest rates.

Manic-depressive Psychoses.—First admissions with manic-depressive psychoses totaled 3,621 in New York State during the three years ended June 30, 1931. Of these 2,192 were native and 1,423 foreign born. Nativity was unascertained in 6 cases. Rates of first admissions are given by nativity classification in Table 8.

TABLE 8.—NUMBER OF FIRST ADMISSIONS WITH MANIC-DEPRESSIVE PSYCHOSES, TO ALL INSTITUTIONS FOR MENTAL DISEASE IN NEW YORK STATE FROM 1929 TO 1931, CLASSIFIED BY NATIVITY AND PARENTAGE, WITH AVERAGE ANNUAL RATES OF FIRST ADMISSIONS PER 100,000 POPULATION

	Number			*Average annual rate per 100,000 population*		
	Males	Females	Total	Males	Females	Total
Native born	892	1,300	2,192	6.7±0.3	9.6±0.3	8.2±0.2
Native of native parents	445	573	1,018	6.7±0.4	8.6±0.4	7.6±0.3
Native of foreign parents	303	536	839	6.1±0.4	10.5±0.5	8.4±0.3
Native of mixed parents	144	191	335	8.7±0.8	11.0±0.9	9.9±0.6
Foreign born	545	878	1,423	11.0±0.6	19.1±0.8	14.9±0.5

The average annual rates of first admissions per 100,000 population were 8.2 and 14.9 for native and foreign born respectively, the latter being in excess in the ratio of 1.8 to 1. Natives of native parentage had the lowest rate, though this did not differ significantly from the rates of natives of foreign or mixed parentage. Among males the rate of the foreign born exceeded that of the native born in the ratio of 1.6 to 1. Among the native born, those with foreign parentage had the lowest rate. These rates are all less than the corresponding rates among females. Foreign-born females had a rate

which exceeded that of native females in the ratio of 2.0 to 1. Among the native born, the rate increased from a minimum of 8.6 among those of native parentage to 11.0 among those of mixed parentage, though the differences are not statistically significant.

Rates of first admission are shown by age for males and females in Table 9.

Among males the rates fluctuate with some degree of irregularity, but in general they increase to maxima in the fourth and fifth decades, and decline to minima at advanced ages. The foreign born have higher rates than the native born through the interval forty to forty-four years. Thereafter the rates of the native born are markedly in excess. Among natives of native parentage the rates at fifty years and over are in excess of those of the foreign born. Natives of foreign parentage have rates practically equivalent to those of natives of native parentage through the interval thirty-five to thirty-nine years. They are less than those of the foreign born through forty to forty-four years, but are in excess thereafter. Except for the youngest intervals, natives of mixed parentage have higher rates than any other nativity group.

Among females, the foreign born have higher rates than natives of native parentage through the interval fifty-five to fifty-nine years. Natives of foreign parentage have lower rates than the foreign born through forty to forty-four years, but higher rates thereafter. Natives of mixed parentage have higher rates than any other group after forty-five years.

These trends are applied in the computation of standardized rates of first admission for the several nativity groups. The population of the state of New York, aged fifteen years and over on April 1, 1930, was taken as the standard. The rates are summarized in Table 12.

The native born had a standardized rate of 12.5 per 100,000 population, compared with a rate of 15.8 among the foreign born. The latter rate was in excess by 26 per cent, compared with a corresponding excess of 82 per cent on the basis of crude rates. Natives of native parentage had the lowest rate, 11.1, though this does not differ significantly from the rate of 12.7 among natives of foreign parentage. Natives of mixed parentage had a rate in excess of those of both natives of

TABLE 9.—AVERAGE ANNUAL RATES OF FIRST ADMISSIONS WITH MANIC-DEPRESSIVE PSYCHOSES, TO ALL INSTITUTIONS FOR MENTAL DISEASE IN NEW YORK STATE, FROM 1929 TO 1931, CLASSIFIED ACCORDING TO SEX, NATIVITY, PARENTAGE AND AGE

	MALES					FEMALES				
AGE (YEARS)	*Total native born*	*Native of native parents*	*Native of foreign parents*	*Native of mixed parents*	*Foreign born*	*Total native born*	*Native of native parents*	*Native of foreign parents*	*Native of mixed parents*	*Foreign born*
15–19	6.2	5.7	5.5	10.6	7.8	9.4	7.1	10.8	9.9	18.6
20–24	12.0	11.0	11.0	16.9	18.5	15.3	11.2	17.5	21.5	23.4
25–29	8.9	8.8	8.9	8.1	10.0	16.3	13.4	19.9	14.6	27.3
30–34	8.9	8.9	8.7	6.9	12.6	16.8	14.9	19.0	16.7	27.7
35–39	11.4	10.1	10.7	14.8	11.1	17.2	14.7	20.6	19.2	26.5
40–44	10.8	10.4	8.6	16.2	14.5	17.5	16.7	14.9	22.0	22.5
45–49	12.9	10.6	13.5	20.6	10.8	18.2	16.2	17.6	19.1	16.3
50–54	16.3	16.0	14.3	18.1	13.4	17.3	15.1	18.3	21.4	17.3
55–59	14.3	12.2	14.2	22.6	10.4	12.0	12.7	9.9	14.8	14.1
60–64	11.2	11.0	10.3	15.0	6.8	11.3	10.2	11.7	12.9	5.5
65–69	6.9	5.2	6.4	14.7	2.7	6.9	4.9	7.4	8.2	3.8
70 and over	5.0	5.6	....	18.3	2.5	3.2	2.9	3.8	3.6	0.4

native parents and natives of foreign parents. Their rate was practically identical, however, with that of the foreign born.

Among males the standardized rates were 10.4 and 11.5 for native and foreign born, respectively, a difference without statistical significance. Natives of foreign parentage had the minimum rate of 9.7, but this was practically identical with the rate of 9.8 among natives of native parentage. The highest rate, 14.3, occurred among natives of mixed parentage.

Among females there were standardized rates of 14.7 and 20.4, among natives and foreign born, respectively, the latter being in excess by 39 per cent, a material reduction, however, from the excess of 99 per cent indicated by crude rates. The lowest rate, 12.6, occurred among natives of native parentage. Natives of foreign parentage had a lower rate than natives of mixed parentage or the foreign born, though in view of the large probable errors, some of the differences must be interpreted cautiously.

Dementia Praecox.—White first admissions with dementia praecox totaled 6,962 during the three years ended June 30, 1931. Of these 4,067 were native and 2,883 foreign born. Nativity was unascertained in 12 cases. Average annual rates of first admissions are shown in Table 10.

TABLE 10.—NUMBER OF FIRST ADMISSIONS WITH DEMENTIA PRAECOX, TO ALL INSTITUTIONS FOR MENTAL DISEASE IN NEW YORK STATE FROM 1929 TO 1931, CLASSIFIED BY NATIVITY AND PARENTAGE, WITH AVERAGE ANNUAL RATES OF FIRST ADMISSIONS PER 100,000 POPULATION

	Number			*Average annual rate per 100,000 population*		
	Males	Females	Total	Males	Females	Total
Native born	2,291	1,776	4,067	17.3±0.4	13.2±0.4	15.2±0.3
Native of native parents	882	696	1,578	13.2±0.5	10.4±0.5	11.8±0.3
Native of foreign parents	1,081	782	1,868	21.9±0.8	15.4±0.6	18.6±0.5
Native of mixed parents	328	298	626	19.9±1.3	17.2±1.2	18.5±0.9
Foreign born ...	1,554	1,329	2,883	31.4±0.9	28.8±0.9	30.2±0.7

Natives and foreign born had rates of 15.2 and 30.2, respectively, the latter being in excess in the ratio of 2.0 to 1. Natives of native parentage had the lowest rate, 11.8. Among

males the foreign born had a rate which exceeded that of the native born in the ratio of 1.8 to 1. Natives of native parentage had the minimum rate of 13.2. Among females the rates varied from a minimum of 10.4 among natives of native parentage to a maximum of 28.9 among the foreign born.

Average annual rates of first admission are shown according to age in Table 11.

Among males the rates rise to early maxima between twenty and thirty years of age. Among females the maxima are reached about ten years later. It may also be noted that males have higher rates than females through the thirties, but that after forty the females have generally higher rates.

Among males the foreign born have higher rates than the native born in each interval, excluding the interval sixty-five to sixty-nine years. The lowest rates are shown by natives of native parentage. Of the native born, those of mixed parentage show, generally, the highest specific rates. These, in turn, are generally exceeded by the rates among the foreign born. Females show the same general trends as males.

In the light of these variations, we may consider standardized rates of first admission, the standard population being that of the state of New York aged fifteen years and over on April 1, 1930. These rates are shown in Table 12.

The native born had a standardized rate of 22.2 per 100,000 population; the foreign born, a rate of 32.8. The latter rate is in excess by 48 per cent, an excess only half of that indicated by the crude rates. Natives of native parentage had a minimum rate of 16.9. Natives of foreign and of mixed parentage followed with rates of 26.4 and 28.1, respectively. These rates do not differ significantly from each other. They are both significantly lower, however, than the rate of the foreign born.

Males and females show trends similar to the preceding. Among males the standardized rates are 24.7 and 37.4 for native and foreign born, respectively, the latter being in excess by 51 per cent. Among females the excess of the rate of the foreign born amounts to 44 per cent. Among both sexes natives of native parentage show the lowest rates.

TABLE 11.—AVERAGE ANNUAL RATES OF FIRST ADMISSIONS WITH DEMENTIA PRAECOX, TO ALL INSTITUTIONS FOR MENTAL DISEASE IN NEW YORK STATE FROM 1929 TO 1931, CLASSIFIED ACCORDING TO SEX, NATIVITY, PARENTAGE AND AGE

	MALES					FEMALES				
AGE (YEARS)	*Total native born*	*Native of native parents*	*Native of foreign parents*	*Native of mixed parents*	*Foreign born*	*Total native born*	*Native of native parents*	*Native of foreign parents*	*Native of mixed parents*	*Foreign born*
15–19	22.1	15.4	28.5	18.0	47.6	10.5	6.9	13.0	12.4	11.7
20–24	46.6	34.8	58.2	44.5	65.7	31.0	16.4	25.3	18.8	26.4
25–29	43.8	37.2	48.4	53.4	59.5	23.7	19.4	26.3	27.8	35.3
30–34	32.6	25.4	37.0	45.0	44.9	27.3	21.4	31.2	36.5	39.8
35–39	29.1	20.1	34.6	44.3	42.0	28.5	25.0	30.5	35.2	41.2
40–44	16.4	13.1	21.6	16.2	30.9	25.7	20.6	29.3	34.5	39.9
45–49	15.5	10.6	17.2	32.2	22.1	19.6	13.6	25.5	30.4	34.0
50–54	10.1	6.4	13.0	16.6	19.5	31.3	12.4	28.9	38.7	27.8
55–59	7.5	4.4	9.0	16.4	8.2	14.5	8.8	31.2	16.7	19.0
60–64	4.3	4.4	4.7	3.0	6.8	6.8	3.8	7.0	20.7	11.3
65–69	3.5	3.7	3.9	....	3.2	5.0	2.1	8.4	8.2	6.0
70 and over	0.7	1.0	....	....	1.0	2.9	2.1	3.8	3.6	2.2

Among the native groups, those of mixed parentage showed the highest rate.

From the preceding analysis, it is evident that the foreign born have rates of mental disease in excess of those of native birth. Closer examination shows, however, that the excess is due in very large part to the effects of the age composition of the two populations. Adjusting for such differences, the disparity in the rates is materially reduced. The disparity would undoubtedly be reduced still further through consideration of certain environmental differences. Rates of first admission with mental disease are lowest in the rural environments, and highest in cities.[1] As is well known, the foreign born have a higher percentage of urban dwellers than the native born, and are consequently affected adversely thereby with respect to the relative incidence of mental disease. The data available at present are not sufficient to permit of further standardization with respect to environment, but it is clear that such adjustment must result in a further reduction in the excess of the rate among foreign born. We may, in theory, consider yet further differential conditions, such as economic status and occupational classification. If rates of mental disease are higher among the lower economic and occupational classes, as they very probably are, it is evident that they tend to cause disproportionately high rates among the foreign born. A complete analysis of this type is not practicable at present, but obviously no final evaluation of the true relative liability to mental disease in the several nativity groups is possible until all of these extraneous factors have been eliminated or held constant. Since correction for age, alone, reduced the excess to 19 per cent, it is reasonable to conclude that further adjustments as indicated above would reduce the excess to limits well within those which might arise solely from environmental stresses of one kind or another.

It has been asserted repeatedly and at great length by Dr. Harry H. Laughlin that the crude differences in mental disease between the native and foreign born indicate differ-

[1] See "The Prevalence of Mental Disease Among the Urban and Rural Populations of New York State," by Benjamin Malzberg. *Psychiatric Quarterly*, Vol. 9, pp. 55-87, January, 1935.

TABLE 12.—STANDARDIZED RATES OF FIRST ADMISSIONS TO ALL INSTITUTIONS FOR MENTAL DISEASE IN NEW YORK STATE FROM 1929 TO 1931, CLASSIFIED ACCORDING TO PSYCHOSES, NATIVITY, AND PARENTAGE

	All psychoses *			*Senile* †			*Cerebral arteriosclerosis* †		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Native born	103.2	79.7	91.8	21.7	22.7	24.1	44.8	28.1	37.4
Native of native parents	83.7	66.3	75.2	16.6	16.0	17.7	36.2	22.6	30.1
Native of foreign parents	113.2	87.6	100.9	22.0	28.5	27.7	48.7	31.9	41.3
Native of mixed parents	134.3	99.3	118.0	28.1	34.4	35.1	60.5	36.0	49.9
Foreign born	120.1	95.7	108.8	25.0	33.5	32.2	50.1	39.3	46.0

	General paresis *			*Alcoholic* ‡			*Manic-depressive* *			*Dementia praecox* *		
	Males	Females	Total	Males	Females	Total	Males	Females	Total	Males	Females	Total
Native born	14.2	4.0	8.9	10.8	1.9	6.3	10.4	14.7	12.5	24.7	20.0	22.2
Native of native parents	11.4	3.8	7.6	7.7	1.5	4.6	9.8	12.6	11.1	18.7	15.3	16.9
Native of foreign parents	15.1	3.7	9.3	14.2	2.4	8.3	9.7	15.9	12.7	29.4	23.7	26.4
Native of mixed parents	17.0	4.4	10.6	15.0	2.0	8.5	14.3	16.7	15.4	30.5	26.2	28.1
Foreign born	16.2	**3.6**	9.8	11.4	2.1	6.7	11.5	20.4	15.8	37.4	28.7	32.8

* Population of New York State aged 15 years and over on April 1, 1930, used used as standard.
† Population of New York State aged 45 years and over on April 1, 1930, used used as standard.
‡ Population of New York State aged 20 years and over on April 1, 1930, used used as standard.

ences in biological soundness.[1] It is difficult, however, to believe that differences that can be reduced so rapidly or explained so easily by age considerations alone can have any relation to biological fitness. Furthermore, it will be noted that the natives of foreign parentage had significantly lower rates than the foreign born. Shall we believe that this is due to differences in germ plasm? Natives of foreign parentage obviously are not entirely the offspring of the foreign born included in the preceding analysis. They derive in part from the immigrants of an earlier generation. The latter, as is well known, include a larger population from northwestern Europe than was found among the groups arriving in this country between 1880 and 1920. We are, therefore, comparing, in part, the descendants of one stock with those of another. But the census reports of 1904, 1910, and 1923 showed that the earlier contingent of immigrants—the Irish, Scandinavian, and Germans—had higher rates of mental disease than the later immigrants.[2] In either case, therefore, the natives of foreign parentage included in the present study had lower rates than the first generation of foreign born. It is difficult to believe that the germ plasm has altered in practically one generation. On the other hand, natives of mixed parentage have higher rates than the foreign born. Surely, if biological influences were responsible, this group, too, would have lower rates than the foreign born. Furthermore, in the alcoholic psychoses, the natives of foreign parentage had higher rates than the foreign born. This result is in contrast to that in all the other leading groups of psychoses, in which natives of foreign parentage had lower rates than the foreign born. It is clearly exceedingly difficult, if not impossible, to interpret such a result in biological language. It is far more reasonable to infer that there have been marked changes in the younger generations with respect

[1] See note 2, page 636. See also *A Report of the Special Committee on Immigration and Alien Insane*, prepared for the Chamber of Commerce of the State of New York, 1934.

[2] See *The Insane and Feebleminded in Hospitals and Institutions, 1904* (Washington: Government Printing Office, 1906), p. 21; *Insane and Feebleminded in Institutions*, 1910 (Washington: Government Printing Office, 1914), p. 31; and *Patients in Hospitals for Mental Disease, 1923* (Washington: Government Printing Office, 1926), p. 23.

to habits of drinking. It is, therefore, reasonable to conclude that the variations in rates between the several nativity groups may be more adequately accounted for on the basis of environmental differences than on any hypothetical biological grounds.

SUMMARY

1. The incidence of mental disease, as measured by rates of first admissions, appears to be twice as high among the foreign born in New York State as among the native born. This, however, is a distorted picture, owing to the fact that the two populations do not present comparable age distributions. When standardized on the bases of age and sex, the rate of the foreign born was still in excess of that of natives, but the disparity was reduced to 19 per cent. It is evident, therefore, that the view commonly set forth, and based entirely upon crude rates, to the effect that the foreign born have relatively twice the amount of mental disease prevalent among native born, is a great exaggeration. The lowest rate is found among natives of native parentage. When corrected for age and sex differences, the rate of the foreign born exceeded that of the natives of native parentage in the ratio of 1.4 to 1. Natives of foreign parentage had standardized rates intermediate between those of natives of native parentage and the foreign born. The highest rates were found among natives of mixed parentage.

2. In the senile psychoses, the standardized rate of the foreign born exceeded that of the native born in the ratio of 1.3 to 1. It exceeded the rate of those of native parentage in the ratio of 1.8 to 1. The highest rate occurred among natives of mixed parentage.

3. In psychoses with cerebral arteriosclerosis, the standardized rate of the foreign born exceeded that of the native born in the ratio of 1.2 to 1. It exceeded the rate among natives of native parentage in the ratio of 1.5 to 1. The highest rate occurred among natives of mixed parentage, this resulting from an exceptionally high rate among males in this nativity group.

4. The native and foreign born had standardized rates of first admissions with general paresis of 8.9 and 9.8 per 100,000 population, respectively, the difference being without

statistical significance, however. The rate of the foreign born exceeded that of natives of native parentage, in the ratio of 1.3 to 1. Native females of foreign parentage had a slightly lower rate than females of native parentage. The highest rates occurred among natives of mixed parentage.

5. In the alcoholic psychoses, the standardized rate of the foreign born exceeded that of the natives, the rates being 6.7 and 6.3, respectively, a difference without statistical significance. The rate of foreign born exceeded that of natives of native parentage in the ratio of 1.5 to 1. Natives of foreign or mixed parentage had higher rates than the foreign born.

6. In the manic-depressive psychoses the foreign born had a standardized rate which exceeded that of the native born in the ratio of 1.3 to 1. Compared with natives of native parentage, the corresponding ratio was 1.4 to 1. Natives of foreign parentage had a lower rate than the foreign born. There were no significant differences between the rates of the foreign born and natives of mixed parentage.

7. In dementia praecox the standardized rate of the foreign born exceeded that of the natives in the ratio of 1.5 to 1. Compared with natives of native parentage there was a ratio of 1.9 to 1. The rates of the foreign born were also in excess of those of natives of foreign or mixed parentage.

8. A complete determination of the relative difference in the incidence of mental disease in the several nativity groups requires consideration of environmental and economic factors. It is highly probable that correction for these influences would reduce still further the disparity in the rates of the several groups.

9. There is no evidence that rates of first admission measure differences of a biological order between the several nativity groups. It is more probable that such variations are due to social and other environmental influences.

BOOK REVIEWS

JUVENILE PROBATION. By Belle Boone Beard. (American Sociology Series.) New York: American Book Company, 1934. 163 p.

This "analysis of the case records of five hundred children studied at the Judge Baker Guidance Clinic and placed on probation in the Juvenile Court of Boston" statistically treats of the probation period and subsequent five-year interval in a group serially chosen, beginning on the date of January 1, 1924. A well-written orienting introduction is followed by a chapter on the general make-up and problems of delinquents. The next six chapters deal with the actual technique (and its results) of the probation officer—in the field of home life, physical and mental health, companionship, recreation, work, and education. There is a final chapter on outcomes and conclusions, with appendices illustrating forms and outlines used by the author and by the agencies under study.

It is all written in clear, straightforward fashion with concise summaries at the close of each chapter.

The "five hundred delinquents and their problems" included four hundred boys and one hundred girls. About three-fourths had committed offenses against property (stealing, etc.); approximately one-fourth had engaged in no previous delinquency; over half had delinquency histories of more than one year's standing. There is no adequate picture of the delinquents themselves or their backgrounds, as Dr. Beard goes no further than the clinic's listing of "causative factors in the delinquency." For each child these are no more than the listing, for the delinquency under consideration, of what the clinic staff felt to be the salient sources of the difficulty. Whether the group is of so dreary stuff—their homes, families, and neighborhoods so poverty-stricken of all that goes toward useful and rich living—as in the Gluecks' series from the same court and clinic, one can only guess.

Rather dizzily one now moves through six chapters of tabulations. Seven hundred and seven recommendations for medical attention were made by the clinic; for 404 of these the probation officer attempted fulfillment; in 363 the task was accomplished! "Although the percentage of success on probation is higher for both boys and girls among the persons whose physical recommendations were fulfilled, there is little evidence of a direct relationship between conduct and health." One hundred and ninety-seven recommendations as to recreation were made by the clinic; 96 of these were fulfilled by the

probation officer; and 32 were unsuccessfully attempted! Why does this sort of thing predominate in a book with the insight to record that "in no type of treatment has the probation officer shown more enthusiasm and more persistence (and less good judgment) than in dealing with recreation"?

Outcomes and Conclusions shows just 50 per cent permanent successes and 30 per cent more who showed a "temporary cessation of delinquency." (The previous chapters are filled with correlations between specific procedures and these successes.) Just why this series shows so much higher percentages of success than the Glueck series (begun six years earlier) is not mentioned. Is the material differently selected? Are there differences in definition of or in assiduousness in searching for failure? Perhaps, after all, the Glueck cases were not such failures as they seemed, actually serving for the development of far more efficient methods of handling all these tangled problems.

The book will be of special value to the beginner in probation. Here in well-ordered array are more than sixty "probable causations of delinquency" and a whole army of "things to be done about it." For one who wonders as to practical steps and the general validity of one or another technical procedure here is something of a guide. One may doubt the importance of any of Dr. Beard's finely spun correlations even while admitting that this exaltation of the detailed techniques of probation (Should the family move? Are boys' clubs worth trying? What are the pitfalls and advantages of companionships?) would be of value to one who wonders what is worth trying.

And yet, to the reviewer, this book represents an approach to the whole problem that is false and utterly misleading. Why does the introduction quote the statement that "some one should come to know and to understand the man in so intimate and friendly a way that he comes to a better understanding of himself," while page 64 tells us that to fulfill a clinic recommendation "sometimes the probation officer threatened to report parents to the judge, to fine them, or 'send the child away'"? Have the juvenile court and the guidance clinic freed children from the heavy hand of the criminal law only to bond them to inexorable demands of "recommendations" and statistics? The bombardment of the Gluecks' work and the equally intensive answers from many sources (including the book under review) have used adding machines as ammunition with little regard for real human values. For the child the law lives, punishes, beckons to better things—but it does so only in the person of him who administers it. Clinic recommendations raised (as is now apparently the custom) to that sacrosanct place where they are mistaken for

the persons they were at one time supposed to serve merely substitute one tyranny for another. So and so many recommendations as to family, so and so many recommendations as to physical health, so and so many recommendations fulfilled or not, to be intricately correlated with ordinances broken by chance and instances apprehended by eagle eyes—all this is but mockery of life. What sort of grotesquery is it to juggle with the various percentages of those with "disturbing sex ideation" when we know full well that every one has disturbing sex ideation? The important question is what the total flowing river of the personality's progress through life does about its disturbing sex ideation.

What has come over Boston? What, after all, has come over psychiatrists, social workers, and others everywhere—those who have been writing papers, holding meetings, developing temperatures about magnificent statistics on unimportant matters?

Delinquent children of the city of Boston—children of dirt and poverty, children of broken homes, of niggardly space and ill-kept faith, children of adventure in a pattern that did not allow it, children with yearnings in a pattern that had no answer—in the rivers of their lives for a time have mingled those of Frederick Cabot, William Healy, Augusta Bronner, Hans Weiss, and others in their own way as great as these. When a book is written that measures the effects of this—when some artist can depict life with his pigments instead of merely using life to parade the glory of his colors—then can we know something of what has been happening in Boston. In the meantime let us not lose sight of these—the real issues.

JAMES S. PLANT.

Essex County (New Jersey) Juvenile Clinic.

CRIMINOLOGY. By Albert Morris. New York: Longmans, Green, and Company, 1934. 590 p.

This is a comprehensive and reliable textbook on criminology. Professor Morris' purpose is to bring together within the covers of a reasonably sized volume the major conclusions of criminologists on all the principal aspects of criminal behavior. His method of treatment is to consider the subject in relation to the criminal from babyhood until after release from imprisonment. This enables him to approach the subject in an orderly and perhaps logical manner, and to treat in due proportion phases which are apt to be overemphasized or underemphasized, depending upon the predilections of the author. Although in his preface he has entered a modest disclaimer with respect to originality, the book is, nevertheless, a valuable addition to the literature, particularly in its excellent critical evaluation of the theories now current among criminologists. His emphasis is upon

behavior rather than upon institutions; for this reason he is more concerned with the conduct of criminals, policemen, prosecutors, public defenders, judges, wardens, prison guards, and parole officers than with crime, courts, and punishment.

Following the best informed opinion of to-day, Professor Morris insists with much acumen that "there is no cause of crime." He regards criminal behavior as motivated very much as all behavior is motivated. There are, as Claude Bernard pointed out long ago, two environments in which the organism functions, and each of them conditions its behavior: the internal environment and the external environment in which the behavior takes place. Professor Morris insists that criminal behavior is the result of an interplay of the two environments and that it cannot be too strongly emphasized that for every man this particular behavior pattern "is unique and the results are unique." He divides the factors present in every case of criminal behavior into three groups: (1) the criminal himself, including his entire constitutional make-up, physical and psychic, inherited and acquired, at a given time; (2) his material environment, both natural (geographic, climatic) and artificial (technic); and (3) his social environment. He recognizes that in any particular instance one of these elements may appear more important than the others—as when unemployment may seem to lead directly to criminal behavior—but he urges, in accordance with the best general opinion, that it is the interplay of all the factors that produces the final results.

It is impossible here to do full justice to the wealth of material Professor Morris has brought together. He has taken account of all the important developments in the many ramifications now recognized as belonging to the domain of criminology. This extensive treatment, combined with a definite point of view of his own, makes the volume perhaps the best textbook on the subject that we now possess. At the end of the book he has included a full apparatus for classroom discussions, reports and exercises, together with a selected bibliography, unfortunately limited, however, to English-language titles. The index is far from complete.

HUNTINGTON CAIRNS.

Baltimore.

COMMUNITY HYGIENE. By Dean Franklin Smiley, M.D., and Adrian Gordon Gould, M.D. New York: The Macmillan Company, 1935. 369 p.

This volume, comprising 369 pages with an index, is a revised edition of the original text which appeared in 1929. The revisions include the substitution of recent statistical material for the old,

additions and rearrangements, and a complete rewriting of portions dealing with medical care and its costs.

The book was written originally and primarily as a text for college students, not so much to convey specific knowledge in regard to the necessary steps for applying public-health measures to a community as for the purpose of imparting general information in terms of community-health problems and the general means for their solution.

The authors, after six years' additional experience in teaching since the original edition appeared, are convinced that the teaching of community hygiene has a definite place in undergraduate instruction and that a course in the subject drives home a greater and greater appreciation of the moral and social significance of personal health and a knowledge of the responsibilities that communities must assume in the matter of health. In other words, college students with such instruction are educated to an appreciation of the fact that health cannot be left solely to individual endeavor—that a coördinate endeavor on the part of community groups is necessary. This is evidently the object of the book. Written as an undergraduate text, it is brief, yet it is a straightforward exposition of what every educated layman should know about community health. As is true of all texts of this nature, there are errors of omission in the strictly technical sense.

The book comprises five sections, totaling twenty-five brief chapters, thus lending itself to subject assignments in class teaching. Each chapter contains a well-chosen bibliography as reference for further reading on the subject.

The first section, consisting of one chapter, deals with the high lights of the history and development of public-health work. The second, of eleven chapters, is devoted to the subject of environmental health hazards and their control, embracing a discussion of man as the commonest source of infection for man; of animals as a source of infection for man; of insects and disease; of the relation of the weather and outdoor air and indoor air to health; of the sanitary significance of soil; of water and water supply and disease; of housing and food and health; and of occupational hazards.

The third section takes up the community attack on specific diseases, one chapter being devoted to community problems in mental health; another to community problems in sex hygiene; another to tuberculosis as a community-health problem; and the fourth to the community attack on heart disease and cancer. In this section, the authors review the incidence of mental disease, stating that "perhaps the most important step in the community control of men-

tal disease consists in the psychiatric classification and special education of neurotic children in the schools," and "a second step in the community control of mental disease is the choice of immigrants." The problem of the mentally deficient is briefly reviewed, attention being again called to the importance of the relationship of special classes and special instruction in the public schools and the place occupied by a state institution for the training and education of the feebleminded. The authors state, "The prevention of the propagation of feebleminded stock is of first importance and sterilization of the frankly feebleminded is undoubtedly a wise procedure. That scheme alone does not, however, adequately safeguard society against the lawless imbecile or idiot." Considerable space is devoted to drug addiction, with several errors of omission and commission. Delinquency and criminality are also dealt with in this section, the need for psychiatric study of children at school entrance being again emphasized.

Section IV deals with health problems specific to certain groups, including a discussion of the community's interest in maternity, infancy, and childhood. No mention is made of the rôle that mental hygiene might play in this particular field. This section discusses also health problems and opportunities in the schools, safeguarding health in industry, military health problems, and the health of the rural population.

Section V of the book deals with agencies in the public-health field, discussing the physician, the nurse, the hospital, proprietary remedies, voluntary and official public-health agencies, and a comparison of the results of work in public health in relation to costs.

WALTER L. TREADWAY.

United States Public Health Service.

SOCIAL ORGANIZATION AND DISORGANIZATION. By S. A. Queen, W. B. Bodenhafer, and E. B. Harper. (Crowell's Social Science Series.) New York: Thomas Y. Crowell Company, 1935. 643 p.

Mental health is vastly more than an individual matter. The lives of individuals are constantly being shaped for better or for worse by the interactions between individuals and the society about them. For this reason a special value attaches to a book by sociologists that devotes five of its twenty chapters to such subjects as personal integrity and disorganization, individual and personal inadequacy, the impact of social change, conflict as a response pattern, and accommodation to conflict.

These headings sound abstract. The chapters themselves, however, have to do with highly concrete instances of the effects of social disorganization, such as unemployment, poverty, homelessness, sick-

ness, delinquency, none of which any serious student to-day would consider purely personal or individual concerns. The millions now out of work are not unemployed because they are lazy or incompetent. Nor does individual badness explain the delinquency of a boy brought up in a gang-infested slum. These personal experiences are among the fruits of what the authors call social disorganization. Hence the importance of such affirmative social organization as will not only prevent wreckage, but offer the widest assistance to more excellent living.

With this aim in mind, the three sociologists who prepared this book examine and interpret the processes that make for social disorganization and social upbuilding. Part II studies the forces that affect the lives of three types of group—the family, the neighborhood group, and the "interest group," such as the labor union. Part III examines institutions, economic, political, cultural. Part IV relates these problems to the work of mental hygiene. "Disorganization of personality may result from (1) an inefficient or unstable cultural organization, which fails to promote a satisfactory adjustment between the person and his environment, or (2) failure of the individual to adapt himself to a more or less satisfactory social structure. The latter in turn may be due to (a) inherent or hereditary handicaps and deficiencies, or (b) socially acquired habits and attitudes. The series may operate in either direction." (p. 474.)

The case studies included in the volume make this abundantly clear. The book ably sustains its plea that the lasting hope of successful personality-building lies in approaching the problem through a synthesis of all the sciences and clinical procedures. The suggestion that we need "sociological hygiene" as well as mental is quite to the point. Many of us will heartily agree with the opinion that human energy, instead of being frustrated or spent in harmful aggression, had much better be directed "against the great foes of mankind, disease, poverty, and war."

HENRY NEUMANN.

Brooklyn Ethical Culture Society.

AMERICA MUST CHOOSE. By Henry A. Wallace. (World Affairs Pamphlets.) New York: Foreign Policy Association, 1934. 33 p.

STATESMANSHIP AND RELIGION. By Henry A. Wallace. New York: Round Table Press, 1934. 139 p.

NEW FRONTIERS. By Henry A. Wallace. New York: Reynal and Hitchcock, 1934. 314 p.

Many persons concerned with mental hygiene feel a vivid interest in the question of a mentally healthy environment. A few people, notably Dr. Frankwood E. Williams, have turned to Russia, with its

communist form of government, as offering the complete solution. Of what use is it, they ask, to spend time, energy, sometimes a good deal of emotion, on rehabilitating an individual and then return him to the sort of community that was largely responsible for the onset of his difficulty? Or why talk so constantly of mental hygiene in its preventive aspects and leave out the most important factor in such prevention—an environment that promotes, or at least permits, healthy living? To promote mentally healthy living, the environment must provide opportunities for self-expression, for reaching one's optimum in some pursuit, whether vocation or avocation, for living above the economic subsistence level.

There is in the Cabinet in Washington a man who appears to be thinking constantly along those lines, if one may judge from his writings. At the same time he is not a mental-hygienist, but primarily an agriculturist; the farmer is his chief concern. He apparently believes that making life a rewarding thing for the farmer—emotionally as well as economically—will touch with a healing hand all the life of this country, and that this preventive effort for mental health can be carried on within the framework of our present governmental system.

This review will consider very briefly two of Mr. Wallace's books and one pamphlet. *America Must Choose* is a paper written by the Secretary of Agriculture for the Foreign Policy Association at their request, believing as they did that his speeches showed an understanding of present-day needs. In it he discusses new types of social control which, he believes, are here to stay. One question of interest to those who will read this review is how, given social control, that individual expression which is required for the truest emotional health can be preserved. Wallace constantly emphasizes two qualities which have been widely accepted as essential to mental health in a social environment—an honest facing of facts and a coöperative attitude. For instance, he writes (p. 12), "We cramp the finest possibilities of a civilization when, blinded by local pride, either regional or national, we blink at plain facts." Or, again, "This nation, and all the developed part of the world, has been terribly under the weight of the need to subsist, to keep body and soul together, in the past few years. We can throw off that miserable burden. We can stand as free men in the sun. But we cannot *dream our way* into that future. We must be ready to make sacrifies *to a known end.*" (Italics the reviewer's.)

Wallace's conception of "new dealing with the world," as he calls it, seems in some outstanding ways a different thing from the way the New Deal has turned out, but in spite of the failure of human beings to live up to their highest in the areas of honesty and

coöperation, the Secretary of Agriculture retains his reasoned optimism and affirms that human nature can be changed "because it has been changed many times in the past." He states (p. 25) that the kind of coöperation he means "depends for its strength on a revival of a deep recognition on the part of the individual that the world is in very truth one world, that human nature is such that all men can look on each other as brothers, that the potentialities of nature and science are so far-reaching as to remove many of the ancient limitations. This concept . . . must grow side by side with a new social discipline which leaves free the soul of man. Never has there been such a glorious chance to develop this feeling as in this country to-day."

In *Statesmanship and Religion* an emphasis that kept appearing in the pamphlet reviewed above is more definitely manifest—Wallace's deep concern with religion and his tendency to apply its teachings and spirit to all the affairs of his country. This little book contains the substance of lectures given at the Chicago Theological Seminary in 1934 and a talk before the Federal Council of Churches in December, 1933. It takes its text from the lives and words of the Hebrew prophets and from the great Protestant reformers. In the preface, he asks the questions: Is our spiritual life to-day awake to the need for social justice? Have we souls rich enough to endure abundance? Having an abundance seems to lessen intensity of conviction, such as was held by the Hebrew prophets and by the later reformers who followed in their train. And lack of conviction, one feels sure, is a hindrance to complete mental health.

Leaders "who are willing to think more fervently and vigorously than most of our leaders have hitherto" are needed if the mass of the people is to be led into ways of health. Unless the leaders have courage and vision, the people will perish, certainly so far as their spiritual lives are concerned. And a deep and earnest spiritual life, one that may be called on when depression prevails—as may a reserve water supply in time of drought—is one sign of vigorous mental health.

In the problem of learning to live with one another and with the rest of the world, the vision of social justice must be clear and well-defined, as was that of the prophet Amos; earnestness, definiteness of aim, the discipline of the daily life must be as completely present as in the lives of Luther, Calvin, and Knox. But something more is needed if we are to undertake successfully the "great spiritual adventure of our age." "Is it possible," asks Mr. Wallace, "that the world is finally ready for the realization of the teaching of Jesus, the appreciation of the Sermon on the Mount, the bringing of the kingdom of Heaven to earth?" From the work of the great

reformers has come a tremendous energy, resulting in the creation of democratic institutions, in scientific discovery, and in the production of wealth. But the "heart of religion which has to do with faith in the values of a higher world, with the cultivated joy of the inner life which comes from an inner spiritual strength," is increasingly lacking. Only this type of religious life will enable society to cope with the problem now confronting it. Courage and steadfast desire for such a spiritual insight, equivalent in amount to our increasing scientific understanding, are essential qualities of this renewed religion, along with the release of the human spirit from the static qualities of the older religious attitudes. This later religion must be dynamic and practical, and the author expresses again his reasoned optimism by asserting that religion—and by that he means "the force which governs the attitude of men in their inmost hearts toward God and toward their fellow men"—is "the most practical thing in the world."

It can be realized only by changing human nature, for "the chief difficulty is with human hearts and human wills." Men "must develop the capacity to envision a coöperative objective and be willing to pay the price to attain it." To bring about this new deal with the world, men must have deep convictions of its worth and of the capacity of human wills and hearts to bring about that social justice which shall result in the brotherhood of men around the world. Can any one deny the effectiveness of such convictions for mental hygiene, and the effectiveness of the resulting community for mental health?

In *New Frontiers,* Wallace's latest book, this mentally healthy community is described in all the detail of business and farm statistics. But all the way through the book, appearing like gleams of light through the murk of facts and figures, are telling comments on those qualities which most mean mental health—courage, an honest facing of facts, willingness to coöperate. This country, perhaps more than any other in the world, is facing a parting of the ways. We are between two worlds and before us are the new frontiers of a changed order, one in which "beauty and justice and joy of spirit must be worshiped as power and wealth have been." Our forefathers, in learning about the resources of the world they were conquering, did not know how to live with one another, nor how to teach the American nation to live with other nations. "The land beyond the new frontier will be conquered by the continuous social inventions of men whose hearts are free from bitterness, prejudice, hatred, greed, and fear; by men whose hearts are aflame with the extraordinary beauty of the scientific, artistic, and spiritual wealth now before us, if only we can reach out confidently, together."

No clearer, more inclusive definition than this could be given of a mentally healthy community.

ELEANOR HOPE JOHNSON.
Hartford School of Religious Education.

THE CHANCES OF MORBID INHERITANCE. Edited by C. P. Blacker. Baltimore: William Wood and Company, 1934. 449 p.

The editor of this volume, Dr. C. P. Blacker, who is general secretary of the Eugenics Society of Great Britain, has secured the coöperation of a number of medical specialists and two geneticists in preparing statements on the hereditary factor in various fields of medicine, including nervous disorders, mental disorders together with mental deficiency, diseases of the eye and of the ear, allergic diseases, those of the blood and vascular systems, those of the kidney, the skin and gastrointestinal tracts, the thyroid gland, the skeleton, and various general diseases such as diabetes, tuberculosis, and tumors. The well-known geneticist, Prof. R. R. Gates, writes an introductory chapter on genetic principles.

While, in general, composite works are apt to show repetition and diverse methods of treatment of the subject matter, in this case, owing to the excellence of the editorial work done by Dr. Blacker, there is extraordinary harmony and uniformity of treatment and a lack of serious repetition.

A perusal of the book shows the tremendous change that has come over the medical profession in their attitude toward heredity. The genetic factor is assumed by all of the writers. The principal discussions relating to this factor are questions of dominance, recessiveness, multiple factors, and the extent to which the expression of the genetic factor may be influenced by a non-genetical.

Since the chapters on nervous and mental disorders are of the greatest interest to readers of MENTAL HYGIENE, these chapters (which constitute two-fifths of the book) may be used to illustrate the general treatment throughout. Dr. W. Russell Brain discusses hereditary nervous disorders and in doing so covers practically the whole field. Extensive pedigrees are given of some of these disorders, such as hereditary ataxia, peroneal muscular atrophy, myotonia congenita, and others. Of course it is not possible always to detect the genetical factor, but in most cases its presence cannot be denied. Brain also treats of the inheritance of epilepsy, of whose importance he has no doubt, despite what other medical men may have expressed, adversely, upon the subject.

Dr. Aubrey Lewis discusses the inheritance of mental disorders and recognizes that "it is not sufficient to be aware that 'G.P.I. is caused by the spirochaete,' or that 'traumatic psychosis is secondary

to gross injury to the brain.' '' He recognizes that internal factors are always important. The author discusses blastophthoria, of which alcohol and syphilis are cited as important agencies. He doubts the importance of alcohol, syphilis, and certain metals as exclusive factors, considering it more probable that they have a parakinetic rather than an idiokinetic significance—that is, they are external agencies which permit genetic weaknesses to show themselves.

The author discusses the principles that should guide a physician in meeting the inquiries of those who seek advice as to marriage where a familial mental disorder is involved.

Dr. Henry Herd discusses the inheritance of mental deficiency in less than forty pages. This space is hardly adequate for a treatment of so vast a subject.

The value of the book is enhanced by numerous pedigree charts, by references (which are often very incomplete), by a glossary of genetic and psychiatric terms, and by a brief treatise by Hogben upon the analysis of pedigrees, a matter of great importance in human breeding where the number of offspring of a given pair is so small.

Altogether, the book is an excellent summary of our knowledge of the matters of which it treats. It will no doubt be a standard English work for years to come.

C. B. Davenport.

Carnegie Institution of Washington.

The Biology of the Individual. Association for Research in Nervous and Mental Disease. Baltimore: The Williams and Wilkins Company, 1934. 323 p.

This volume is the fourteenth in the series issued in uniform format by the Association for Research in Nervous and Mental Disease. It contains the papers and discussions of the Association's 1933 meeting under the presidency of J. Ramsey Hunt. It represents an awareness, on the part of the leaders of that organization, of the important functions of the ''individual as a whole,'' and an attempt, under the guidance of Dr. Hunt, to bring together the most firmly established knowledge and the most reliable opinions bearing upon these functions.

Jelliffe introduces the topic with an historical essay in his characteristically erudite and allusive style. Barker expounds the conception of the ''phenotypic'' constitution which is determined in part by genetic factors and in part by experience. Gesell exhibits a similar breadth of view in terms of the ''relatively stable'' and the ''relatively labile,'' but presents here more particularly his material on monozygotic twins, emphasizing the maturational limitations. Timme

presents in 28 photographs a sampling of the effects of the less common endocrine disorders on body-build. Henry gives his observations on body-build and habitus in relation to heterosexual, homosexual, and narcissistic types of adjustment. Davenport discusses with somewhat disappointing brevity the inheritance of types of body-build and their association with disease. Stockard's interesting presentation of his genetic studies on the morphology of dogs has been omitted from the published volume, except for a fragment of the discussion, which appears after James's paper on conditioned reflexes in the dogs. The latter's experiments, which were limited to just one type of situation—food taking—did not separate the animals into morphological types. Goldzieher's clever essay on biochemical aspects of constitution may be criticized as too credulous (*e.g.*, about Zondek's work on bromine), but plausible. Todd discusses the progress of physical maturity in relation to mental expansion. He presents cases illustrating the use of his epiphyseal rating plan and the light it throws upon the mental aspects of irregular development. Typological ideologies are presented by Kahn and by Klüver. Sociological considerations receive attention from Floyd Allport and Healy, and indirectly from Schilder, who emphasizes particularly the great importance of the super-ego and related psychoanalytic concepts for the understanding of personality and character development. Rorschach tests and graphology are dealt with by Diethelm. Quantitative data accumulated during the Worcester study of schizophrenia are analyzed, correlated, and presented by Hoskins and Jellinek. They emphasize the general picture of inefficiency, but recognize the "ability of the [schizophrenic] patient under stimulation to rise to normality in a great variety of individual functions."

The papers by Campbell and Bowman may be specially cited as illustrating the fascinating, but baffling problems in the clinical field. The former presents clearly and forcibly the obligations and opportunities of the psychiatrist to analyze the patient's personality; the latter reports an elaborate statistical inquiry into pre-psychotic personality traits. The attempt to work out significant items of personal biography into generalized descriptive terms, and to obtain a consensus of opinion in evaluating such "traits," raises an "almost insurmountable" difficulty; but some attempt in this direction is required in order to substantiate convincingly the validity of "understanding" the patients' biographies. Bowman did not solve all these difficulties. Perhaps others may achieve something more concretely factual than his coded scheme of evaluating traits. But with all its imperfections, this report indicates certain statistical associations, of which this reviewer considers three to be specially important: (1) the markedly more sympathetic pre-psychotic dispositions of the "affec-

tive'' group of patients; (2) the apparent fact that patients, pre-psychotically, daydreamed less than did normal persons; and (3) the degree of agreement, rather than contrast, in the pre-psychotic traits of patients in the two major functional groups, schizophrenic and affective, particularly the high incidence of ''model children,'' the persistence of ''sensitiveness'' into adult life, and the tendency to be close-mouthed and uncommunicative.

This volume, rather more than others in the series, creates an impression of uneven and sporadic progress, tinctured with self-conscious apologetics. It probably reflects correctly the state of knowledge and opinion in this field, whose own inherent difficulties are multiplied by the still-lingering prejudices of a ''scientific'' ideology which has been too exclusively organ-oriented. The publication of this volume registers a major change in attitude and should encourage a more sustained advance.

J. C. WHITEHORN.

McLean Hospital, Waverley, Massachusetts.

FRANZ ANTON MESMER: A HISTORY OF MESMERISM. By Margaret Goldsmith. Garden City, New York: Doubleday, Doran, and Company, 1934. 308 p.

In view of the steady stream of books that pour from the printing presses each year on the mind and its functions and on behavior and its causes, it is surprising that so few attempts have been made to give an historical picture of psychotherapy. Popular interest in psychology has apparently not taken the direction of tracing methods of therapy. Certainly, there is no recent study in English readily available to the intelligent layman. This volume, therefore, serves a very useful purpose.

Miss Goldsmith starts her history by stating that, through the ages, man has consistently tried in various ways to cure certain kinds of diseases without drugs and that miraculous cures have been brought about by various religious and secular rites and rituals. Primitive peoples blamed evil demons for their loss of health. (That this idea still persists to-day in corners of the world not considered backward, is proved by the trials of ''hex'' doctors that occur from time to time in southern Pennsylvania and elsewhere.) After a few remarks concerning Greek and Roman practices, the author gives an interesting analysis of the faith healing of Jesus. She points out that he prepared the minds of the sick for the cure that was to come and convinced his disciples that they had the ability to heal. As a result, both pupil and teacher had the correct attitude of mind toward the therapeutic process. One might have wished that this religious material had been developed a little more fully and that reference had

been made to some of the modern critical theological expositions on the subject, with their interesting comments and interpretations.

Coming now to the main section of the book, from which the whole study takes its title—the life and contribution of Mesmer himself—one finds the facts lucidly presented in 150 pages. "It was chiefly due to Mesmer and his disciples," Miss Goldsmith points out, "that the idea of the power of the mind over the body was slowly emancipating itself from a belief in cures by magic or religion to a more scientific outlook. His theories bridged the gap between ancient superstitions and modern psychotherapy." This is a clear statement of Mesmer's place in psychiatric history. Miss Goldsmith also shows that it was one of the regrettable facts of the past that Mesmer did not understand the force that was operating behind his "animal magnetism." Although he knew that certain persons could, and others could not, be magnetized, he did not realize the basic importance of suggestion and recognize that this was the secret of his success as a healer. At any rate, he never acknowledged that the power to cure emanated from his own personality and was founded upon the sympathetic relationship existing between physician and patient; nor did he discover apparently, although he came so close to it, the control of the mind over the body.

The last six chapters of the study, consisting of slightly over a hundred pages, take up some of the developments in psychotherapy that grew out of Mesmer's work. The first really important contribution was made by Count Maxime de Puységur during Mesmer's lifetime. He published a treatise in 1784 setting forth the discovery that by means of what is now called hypnosis one person could influence, for good or ill, the mental condition of another. This threw a great light upon that twilight zone between consciousness and unconsciousness and explained the phenomenon of sleep-walking, which had long puzzled scholars. Puységur proved, however, that these reactions could be produced during hypnotic sleep. The first period in the history of mesmerism comes to an end with the work of Deleuze, Puységur's most distinguished pupil, who was convinced of the existence of the magnetic fluid, but who believed that it was controlled by the human will.

Early in the nineteenth century, the demonstrations of Abbé Faria were attracting much attention in Paris. He held public séances—but, more significant, he suggested that magnetic cures were brought about by the receptive attitude of the patient and depended upon the rapport between the magnetizer and his subject. This conclusion led directly to the serious work of Alexandre Bertrand, a well-trained and brilliant young physician, to whom we owe the modern theory of suggestion. Unfortunately, Bertrand's studies were ignored by his

confrères and his untimely death in 1831, at the early age of thirty, delayed the progress of psychological medicine for several generations.

In the succeeding decades the field was largely left to the charlatans and near-charlatans, although here and there a qualified physician, like John Elliotson in England or James Esdaile in India, was interested in the subject. As a matter of fact, ever since Mesmer's day, the interest in psychic phenomena has taken two different directions—toward science and toward quackery—between which it is often extremely difficult to distinguish. During the past century and a half, there have always been isolated physicians who have used hypnosis or suggestion as a therapeutic agent in the cure of disease; and there have been other practitioners of a most varied and motley kind who have gone off on tangents such as clairvoyance, spiritualism, telepathy, New Thought, theosophy, Christian Science, or the like. As Podmore points out regarding the latter group in his illuminating book, *Mesmerism and Christian Science,* published in 1909, there were in addition to hypnotism "three distinct schools of thought, each claiming a scientific foundation, whose descent may be traced directly back to that universal system of knowledge whose boast it was to unite two well-known sciences—Astronomy and Medicine. The three faiths in question are the fluidic theory, which finds its headquarters, appropriately enough, in modern Paris; the religion of modern Spiritualism; and the movement of Mental Healing, of which the sect known as Christian Scientists are the most prominent representatives."

We, however, are more interested in the medical applications of Mesmer's work. To turn, therefore, to that aspect of the subject, the next important figure in the development we are tracing was James Braid, an English surgeon, who coined the word "neurohypnotism," later shortened to hypnotism, the term now generally used. His important book appeared in 1843; this work and articles published in the *Medical Times* slowly won some degree of scientific recognition. But it was not until 1860, when as an old man he sent a comprehensive résumé of his theories to the French Academy of Science, that Braid finally aroused the interest of serious students. The results of the reading of this paper, as Miss Goldsmith shows, were to make curiosity regarding psychological phenomena respectable in professional circles and to enlist the enthusiasm of one young doctor, Ambroise-August Liébeault, who was to direct Braid's ideas into modern channels. Treatment along these lines was inaugurated at Nancy by Liébeault and Bernheim and at Saltpêtrière by Charcot and his co-workers.

Charcot was a distinguished neurologist who discounted psychological factors and, as was to be expected, concentrated attention on the physical manifestations of hypnosis. He believed that hypnotism

was an abnormal condition related to hysteria and not a therapeutic means to an end. The Nancy group, on the contrary, were vitally concerned with the value of hypnosis as a therapeutic tool and used suggestion during hypnotic sleep as a means of curing mental disorders.

The work of these notable French physicians leads without deviation to the outstanding contribution of that other great Austrian physician who, like Mesmer, has been repudiated by the orthodox medical circles of Vienna. This is not the place to discuss Freud's epoch-making contribution or the doctrines and theories of psychoanalysis. Suffice it to say, as Miss Goldsmith points out, that Freud is the originator of our modern conception of the subconscious mind and that he "emancipated nervous disorders and psychological conflicts from moral values. A mental maladjustment, however it may be expressed in action, is an illness, and should therefore not be judged by standards of 'right' or 'wrong.' This new point of view is as important a contribution as the one Mesmer made when he separated cures without drugs from medieval superstitions."

It will be seen from this brief summary that Miss Goldsmith's book deals with important material in an intelligent manner. It would have been an even more satisfactory piece of work if the data had emerged a little more definite and clear-cut in outline and if her style had been a little more interesting and vivid. It is unfortunate, likewise, that her book appeared so soon after Stefan Zweig's excellent study, *Mental Healers*, and that so little reference was made to his striking portrait of Mesmer. Of course, any comparison with Zweig is a little unfair, because at his best he possesses a rare ability to make words sing and to appraise a man's life work in a few vivid sentences. The rest of us have to be satisfied if we are good craftsmen. This Miss Goldsmith is—and her book is one that any person interested in the development of psychotherapy will wish to read.

Metropolitan Life Insurance Company. BESSIE BUNZEL.

SAMUEL GRIDLEY HOWE. By Laura E. Richards. New York: D. Appleton-Century Company, 1935. 283 p.

In this interesting, lightly sketched portrait of her father, Mrs. Richards fondly depicts him as a nineteenth-century knight in shining armor, a veritable Bayard, *sans peur et sans reproche*. Anachronistic though it might be, the idea of chivalry seems to have been inseparably linked with the character of Howe in the minds of his intimates and acquaintances. His friends called him Chevalier, or "Chev" for short. Whittier, in his poem, *The Hero*, pointed to Howe as living proof that the chivalric qualities of unbending courage and gentleness could still be found combined in one man. Under the circumstances, we can hardly criticize Mrs. Richards, who moved

about constantly in the orbit of his resplendent presence, for portraying him as a figure all light and no shadow, a sun without spots.

The three-quarters of a century spanned by the life of Howe (1801–1876) witnessed two important developments in the history of American social welfare, upon both of which he exercised a deep influence. Born into a period characterized by the haphazard, patchwork welfare of pioneer communities, with attendant neglect and cruelty toward dependent classes, he became one of the foremost leaders in the stage—which might be termed "the age of romanticism" in the social services—when welfare work was largely in the hands of enthusiastic individual experimenters, and he lived to be a major participant in the first great step toward the centralization of public welfare in the hands of the state.

Howe is best known to the general public in connection with his work for the blind, but for readers of MENTAL HYGIENE, special interest attaches to his activities in behalf of the insane and the feebleminded. In 1841, his attention was called to the tragic plight of the insane by Dorothea Lynde Dix, who was then embarking on her long life of service to "that most unfortunate class of society's pariahs." He became her enthusiastic supporter, and by writing timely, firsthand accounts of the conditions of the mentally ill in the jails and poorhouses of Massachusetts, provided a firm buttress for her stand. Her own shocking revelation of inhumanity might otherwise have gone unheeded as the vagaries of a meddlesome woman. As a member of the Massachusetts House of Representatives in 1843, Howe introduced Miss Dix's famous memorial to the legislature—the first of many submitted by her to similar bodies throughout the country in behalf of the insane—and succeeded in obtaining favorable action on her appeal. It was this initial success, gained with the valuable aid of Dr. Howe, that emboldened Miss Dix to carry on her great crusade through two continents over a period of forty years.

Howe's own most distinctive achievement in the service of the handicapped classes undoubtedly lay in his pioneering work with the feebleminded. On one of his visits to Europe, he had observed Dr. Edouard Séguin's educational experiments with the mentally defective at the Bicêtre in Paris, and had been much impressed by them. In 1845, he started a movement for the better care and treatment of this handicapped group in his native state. The following year, the Massachusetts legislature appointed him chairman of a commission of three to inquire into the extent and treatment of mental defect in the commonwealth. The survey revealed that hundreds of "idiots"—a term then generally used to cover all grades of mental deficiency—were living in conditions of appalling brutish-

ness, objects of barbaric treatment on every hand. Many of these, Howe reported, could be educated to greater or less degrees of self-help, and some even could be reclaimed to positions as self-supporting members of the community. At the time, "idiots" were popularly considered to be beyond all hope of betterment and, indeed, beyond the pale of human sympathy.

Howe was determined to establish an experimental school for the feebleminded. His plan was everywhere ridiculed; he was widely caricatured as a Don Quixote tilting at windmills. It was whispered: "What do you think Howe is going to do next? *He is going to teach idiots!*" Undeterred, he pursued his design and persuaded a skeptic, but tolerant legislature to appropriate $2,500 annually for a period of three years toward the support of the institution. Thus was born the "Massachusetts School for Idiotic and Feeble-Minded Youth"—the first of its kind in America. Its success, now a matter of inspiring history, had the effect of stimulating the erection of similar institutions throughout the country. With much truth, Howe's worthy successor, Dr. Walter E. Fernald, characterized his work with the feebleminded as "the chief jewel in his crown."

There was hardly a progressive social movement of Howe's time that did not feel the influence of his active support. He was an ardent advocate of penal reform, and did much to improve the prison system of his own state. He proved a mountain of strength to his friend, Horace Mann, in the most trying years of the fight to introduce a state-wide common-school system. He was also a prominent figure in the abolitionist movement.

In 1863, he helped organize the Massachusetts State Board of Charities, the first centralized public-welfare body in the United States, and served as its president for nine years. The annual reports he prepared for the board were widely read, and exerted a deep influence on the course of public-welfare administration in this country. His philosophy of social welfare, as epitomized in the famous Second Annual Report of the Board (1865), foreshadowed present-day theory to a remarkable degree.

Altogether, Howe's life was one long record of distinguished service in the many fields of social welfare with which he was connected. In the volume under review, his varied life is but lightly outlined. It is a deeply personal record, rich with fond reminiscences. If to some readers it seems to lack substance, they may turn for greater detail to the two-volume *Journal and Letters of Samuel G. Howe,* compiled by Mrs. Richards some thirty years ago. And if by others it is found lacking in objectivity, they may find this quality more abundantly in the pages of Franklin B. Sanborn's excellent biography of Howe.

ALBERT DEUTSCH.

New York City.

NOTES AND COMMENTS

Compiled by

PAUL O. KOMORA

The National Committee for Mental Hygiene

Sixty-second National Conference of Social Work

If psychiatry and social work can shift their interest from the weaknesses to the strengths of people in distress, they may make a valuable contribution to religion, government, and education. This was the conclusion presented to the National Conference of Social Work at its Sixty-second Annual Meeting in Montreal last June by Dr. Frederick H. Allen, Director of the Philadelphia Child Guidance Clinic. His subject was the influence of psychiatry on social work. Dr. Allen said that the ground of interest common to these two branches of social science is their increasing knowledge of the psychological nature of man. Both are concerned with influences shaping the nature of individuals.

"Naturally," he said, "as our understanding of people increases, our professional practices become modified. Psychiatry has focused the attention of social work more on the causes of behavior and so has led to more preoccupation with the correction of causes as the logical way of changing behavior. This preoccupation with causes has not, however, been an unmixed blessing.

"The individual is not a passive reactor to externals making up his world, but creates feelings in relation to these externals which in turn affect his attitudes. The thing that should interest us most about him is how far he is able to make these adjustments in his own way and on his own strength, without specifically arranged promptings or coercions. Mass environmental changes through social action, such as social insurance, housing, recreational improvement, etc., should provide more opportunities for the individual to manage his own reality with his own energy."

In speaking of "authority," Dr. Allen pointed out that in social work its value should be appraised not so much by immediate results as by its stimulation of the inner strengths of the individual.

"Authority," he said, "utilizes the weaker or submissive side of the self—a danger which cannot be ignored. Failure follows upon the assumption that authority and coercion must go hand in hand. Psychiatry should focus on what the individual can do about himself in a culture which imposes restrictions and allows opportunity. To

this task he brings his accumulated strengths and weaknesses gained in the process of living. The effective utilization of his strengths in handling the responsibility for self without denying the existence of the weaker side becomes the problem both for the individual and for the psychiatrist."

Dr. Allen said that there is little in our present-day culture and in programs designed to alleviate human distress that takes cognizance of the attitude he advocates. We are preoccupied with the weaknesses and disabilities of people. We see them tossed about by the injustices of an economic order. On every side we hear of hardships and the need for material assistance. As a natural sequence emphasis is placed on giving. We lose sight of the essential sturdy strength of people through our preoccupation with what is wrong and through overlooking the more positive facts of human experience.

In discussing Dr. Allen's paper, Miss Madeleine Lay, Case Consultant of the Brooklyn (N. Y.) Bureau of Charities, spoke of the "danger of too active planning by the social worker, which may stir up negative strengths in those who resist living on the experiences and feelings of others, with the result that their negative struggle blocks the emergence of creative possibilities. In this day," Miss Lay said, "many who have formerly been quite adequate socially are becoming clients or patients because the world in which they live has frustrated them or denied them the means of compensating for personal inadequacies. If the social worker further frustrates the client, through a denial of his wishes, or by imposing her wishes upon the client, she may focus upon herself the accumulated hostility which has been generated within the client and has been intensified by his dissatisfaction with the social order, thus wrecking this relationship which is so important to case-work."

Two approaches to the contribution of child-guidance theory to the treatment of behavior problems were made—one in the field of probation, by Dr. Milton E. Kirkpatrick, Director of the Child Guidance Clinic, Worcester, Mass.; the other in the field of the visiting teacher, by Miss Shirley Leonard, Chief Psychiatric Worker, Bureau of Child Guidance, Board of Education, New York City.

Dr. Kirkpatrick declared: "We are on the threshold of an entirely new approach to the problems of juvenile delinquency. Our efforts to reform the behavior patterns of all delinquents coming into court have resulted in failure and widespread personal discouragement." Indeed, there is a question in the minds of some, he said, whether we are not causing delinquency by the very method we are using to correct it.

In forecasting the use of a new method—therapy—in treating juvenile delinquency, Dr. Kirkpatrick pointed out that from the

time the child commits the delinquent act, he is threatened, wittingly or unwittingly, by the entire court procedure. "He is often deprived of his liberty, questioned by police, the neighbors are interrogated, and his school-teachers interviewed. Small wonder that, when he leaves the court, he feels that those whom he formerly counted his friends will no longer trust him. The old legal procedure amongst juveniles is in need of radical surgery, not palliative treatment. Practically all the work done to date in the field of delinquency has been diagnostic in character. There is every indication that in the future our task will be to aid the delinquent in understanding himself."

Dealing with the juvenile court as a rehabilitation agency, Dr. Kirkpatrick said there are too few good juvenile courts and they are seriously handicapped by political and legal traditions. "Probably no other social agency is faced with a task as difficult as the juvenile courts. Our criticism would be that they are not sufficiently impressed with the seriousness of the problem, it being altogether too easy to depend solely upon whatever techniques they possess instead of demanding new ones. We cannot overlook the fact that the distorted mental processes that make for delinquency have existed for varying lengths of time, and it is presuming too much to think that changing of environment or appearance in court will effect a reformation."

Dr. Kirkpatrick declared further that all children's agencies should share the responsibility of treatment of the delinquent child, rather than the juvenile court alone. "All children's agencies have much in common and results can be expected, providing a better integration of effort. The forces that breed delinquency and crime cannot be easily eradicated; they are crystallized in the behavior pattern of the race. The juvenile court never expected to cure delinquency, but it did hope probation would reclaim a certain number who otherwise would continue their careers of delinquency and crime."

Considering the question of treatment of the juvenile offender, he said, "We earnestly advocate some formulated processes by which we can select those cases most likely to profit by what we have to offer. Is there any reason why court workers should not select the children most likely to respond to treatment, leaving the matter of development of techniques for handling the most difficult problems to the research worker?"

Speaking of therapy, Dr. Kirkpatrick divided it into "direct therapy, with the patient or patients and parents, having as its aim the development of insight; and indirect therapy, with those environmental factors which can be modified. This includes school placements, constructive recreation, occupation, and things of like nature.

Good therapy is both an art and a science. It is developed in a highly individualized fashion by the person using it. It conforms in major respects with the scientific doctrines laid down for us."

Discussing the work of the visiting teacher, Miss Leonard asserted that the philosophy of the child-guidance clinic had helped to stimulate the effectiveness of visiting teachers by providing an opportunity for synthetic study of many phases of a child's problem, by changing her case-work technique from a dogmatic, authoritative approach to a more receptive and objective attitude toward individuals. It has shown her the importance of her own emotional drives and the relation between those and the client's reactions. It has revealed to her the symptomatic aspects of behavior.

Urging the schools to provide for the mental health of their pupils, Miss Leonard recalled the changes that have taken place in official attitudes with regard to the school's responsibility toward the physical welfare of their charges. Years ago a health program in the schools was questioned as unnecessary and not the concern of education. Now we take for granted the school's interest in dental needs, speech defects, malnutritution, early cardiac conditions, and other visible handicaps. The school nurse and the school doctor are an accepted part of the system. "Is there not," Miss Leonard asked, "a parallel need in the field of mental health, especially in these distressing times? Can we do less than urge that schools provide an extensive and preventive mental-hygiene program through trained case-workers or visiting teachers attached to their faculties—case-workers who know the schools and who reach out from them into the communities?"

Into the visiting teacher's office, she said, would come teachers to discuss academic and personality failures of their classrooms, mothers who are worried about their child's unhappiness, boys who want to form a Scout troop, case-workers from various agencies wishing some special attention and help for certain school children, members of the parent-teacher group to plan mental-hygiene courses, and so on. Just as the nurse sends serious physical problems on to the hospital, so the visiting teacher would refer her most serious behavior and personality problems to the child-guidance clinic. "With such a mental hygiene set-up in the schools, we might, indeed, provide some helpful backing to other agencies in the community who are trying so desperately to keep the children now growing up from bearing the whole burden of the depression."

In her discussion of Miss Leonard's paper, Miss Marion N. Echols, visiting teacher in the Madison (N. J.) Public Schools, developed an idea that is crystallizing in visiting-teacher work and allied fields—namely, the extension of the visiting teacher's responsibilities to the

classroom teacher and other key people in a position to utilize constructive elements in a problem situation wherever they may appear. It will not be necessary for all teachers to become case-workers, she said, any more than case-workers need to be teachers in order to get the teacher's point of view. But the acceptance by teachers of their responsibility in constructive relationships with children who need help "makes possible a reëmphasis of the function of the visiting teacher as more intensive work is made possible on difficult cases and less and less direct treatment is necessary. Rather than precluding a lessening of the need for the case-worker's professional and more technical services, the door is opened to greater opportunity for intensive therapy, the more adequate teachers become in making not only classroom adjustments, but professional home contacts as well. . . . When a professional discussion ensues regarding the type of treatment necessary to meet the needs of a particular child, and different members of the group, who, in the child's life situation come into natural contact with him, assume responsibility to carry out treatment recommendations, there is being created for these representative members a sense of achievement and personal value that arrives only through coöperation toward a worth-while project. . . . If we, as case-workers, can include in our thinking this concept of leadership training in the principles of mental hygiene as a part of our professional responsibility to any community, will we not be adding a new security in the fields of social work as an indispensable need of community life?"

International Hospital Congress Held in Rome

Mental-health interests came in for a substantial share of the deliberations of the International Hospital Association which met in Rome from May 19 to 26. American psychiatry was represented by Dr. Thomas J. Heldt, Director of the Psychiatric Department of the Henry Ford Hospital in Detroit, who presented a report for the subcommittee on psychiatry. At a joint meeting of the subcommittees on psychiatry, neurology, and mental hygiene, at which Dr. Heldt presided, the following recommendations were made and later approved by the association in plenary session:

> "1. A more uniform international terminology in psychiatry, neurology, and mental hygiene is imperative. It is suggested that a committee be appointed, preferably from the membership of the three committees named, to undertake an inquiry into the recording and reporting of such an international terminology.
>
> "2. All candidates for the degree of doctor of medicine should receive increased training in psychiatry, neurology, and mental hygiene. Definition of minimum requirements is advisable."

Dr. Heldt is chairman of the subcommittee on psychiatry, and Dr. Ralph A. Noble, formerly Director of the Division on Psychiatric Education of The National Committee for Mental Hygiene, is chairman of the subcommittee on mental hygiene.

In another set of resolutions, adopted by the committee on hospital librarians, it was recommended that "due consideration be given to the experience of those hospitals for mental patients where special libraries have already been instituted."

In his report, which discussed the progress made by his committee in evaluating the status of the care of nervous and mental patients in the various countries, Dr. Heldt reviewed the history of institutional care of the mentally sick, and deplored the fact that segregation is still one of the outstanding characteristics of the care of psychotic patients. Fortunately, however, it is becoming more a matter of economy and expediency than of necessity, since during the past fifty years, especially the last ten years, much improvement, much modernizing has been seen in institutional care; and state institutions are being gradually converted from "centers of incarceration and indifference into true hospitals of treatment and understanding training." Further discussing the advances that have been made and the problems and needs still to be dealt with, Dr. Heldt said:

> "We need but be reminded of the many improved methods in the treatment of neurosyphilis to be convinced of the forward progress of therapy in the case of nervous and mental disease. Current articles show the therapeutic effort being brought to bear upon those problems that the state institutions and private sanatoria, with their trained personnel, have so long been grappling with patiently, enduringly, but ever hopeful of remedial interpretation and restitution.
>
> "The therapeutic interval between the normal, healthy, well-adjusted individual and the individual incapacitated by nervous or mental disorder and about to be admitted to institutional care, is indeed an interval laden with many opportunities for prophylaxis and treatment, and medical and social responsibilities of every kind. It is in that time period that the mental-hygiene movement finds its golden opportunities in child-guidance movements, child-guidance clinics, programs for the prevention of delinquency, and many other socio-medical organizations. Responsibilities of like magnitude are placed upon psychiatric, neurologic, and medico-psychologic facilities. Measures of prevention merge into pre-care provisions and the latter grade insensibly into hospital care.
>
> "The committee emphasized the utilization of the general hospital in the care of the neuropsychiatric patient. When it is realized that not less than 86 per cent of all patients admitted to hospitals pass through general hospitals, and when we recall that these same general hospitals during 1933 had 155,000 idle beds, it emphasizes the golden opportunity of being of assistance in the care of the neuropsychiatric patient. Large investments of special hospital facilities and equipment are not necessary. Trained personnel is the need. . . .

"Scientific research and painstaking investigation in the field of neuropsychiatry are highly important. Undoubtedly, research in the function of the vegetative, or autonomic, nervous system and researches in endocrinology will do much to increase our knowledge of the mental disorders. But of no less importance is the urgent need of requiring of all candidates for the medical degree an adequate knowledge of the nature and treatment of nervous and mental disease. Minimum and standard requirements must be such that the newly graduated physician will be able reasonably to recognize and to direct, if not to treat, an incipient mental disorder of whatever nature. Great Britain, Norway and Sweden, the United States, Germany, Switzerland, France, and a number of other nations have already laid down definite standard criteria that must be met by their physicians who would specialize in neurology and psychiatry, but very few, if any, nations have properly solved undergraduate instruction in neurology, psychiatry, and psychology.

"The attitude and viewpoint of the general public is much more dependent upon the viewpoint of the young physician, the general practitioner, and that of the various specialists other than the neurologist and the psychiatrist, than upon the viewpoint of the individual specialist in psychiatry or neurology. Hence, undergraduate medical education in neurology and psychiatry must be emphasized fully as much as the research aspects of the problem of mental disorder. On the other hand, if every physician specializing in neurology or psychiatry has a sufficiently wide general medical knowledge and experience, there is little danger of his straying from a proper consideration of the problems besetting his patient. Diversity of opinion is too often founded on limited training and a grossly narrow point of view.

"The rehabilitation of a patient is almost directly proportional to the amount of personalization or individualization granted that patient. Impersonalization or depersonalization promptly leads to group therapy and from there to economy, expediency, mere custody, and the innocuous desuetude of therapeutic indifference. Open-mindedness, inquiry, application, and understanding remain the watchwords of your committee."

State Society News

Maryland

The efforts of the Mental Hygiene Society of Maryland during the past year have been directed toward the study and treatment of behavior problems in adults and children; the creation of a public opinion favorable to the development of psychiatric clinical facilities and other mental-health projects; public education and the special instruction of those professionally interested in mental hygiene and working in related fields; and the improvement of institutions for the mentally ill and mentally deficient.

The major work of the society is its maintenance of the Baltimore Mental Hygiene Clinic and the Psychiatric Clinic at the University of Maryland, with the financial aid of the Baltimore Community

Fund. The university also helps in the financing of personnel to handle the university hospital out-patient work. Over 1,000 patients were studied and treated at the Baltimore Clinic in 1934, the majority of them children. Members of the clinic staff are also consulted by medical students, nurses, social workers, and others about their individual mental-health problems. Thanks to the society's efforts, the University of Maryland Medical School has increased the time devoted to the teaching of psychiatry from 22 to 76 hours. Approximately 8,000 people were reached through the society's educational work last year, which also saw the extension of its clinical services on a state-wide basis.

New York

A discussion of the mental aspects of unemployment relief was one of the outstanding features of the Twenty-fifth Annual Meeting of the New York State Committee on Mental Hygiene, which was held at the offices of the State Charities Aid Association on June 20, Dr. William L. Russell, Director of the Payne Whitney Psychiatric Clinic at the New York Hospital-Cornell Medical Center, and newly elected chairman of the committee, presiding.

That mental hygiene has much to contribute to the solution of our relief problems was evident from an interpretation of the situation in New York City and State presented by Homer Folks, Secretary of the association. Mr. Folks also described the work of the subcommittee on morale which was created to deal with the mental-health needs of relief clients.

"The psychological and emotional aspects of the relief situation," Mr. Folks said, "are almost beyond the powers of human imagination and analysis to describe. What is the effect of relief upon people? There are new phases when the numbers are so great. You must visualize the fact that in the city of New York, whole tenements, whole neighborhoods, are on relief. In the poorer sections, a new environment has been created and the standards and conduct of living are entirely changed. The change is almost as great as during the War. There is an entirely new set of circumstances. The number of people getting relief in New York City in January, 1935, reached 584,000. About 17 per cent, or one-sixth of the total population of the state, is on relief. I do not have it within my imagination or knowledge to grasp what this means. An important mental-hygiene consideration is, How long can we go on? I am greatly troubled about the huge sums of money involved; $250,000,000 a year in the state of New York alone is a tremendous sum. But what troubles me more is how long the people will be able to stand these conditions. People on relief are not living in a comfortable way; they are living on a subsistence allowance. What will become of

these people who are being reduced to a primitive existence? The richest country in the world is coming back more slowly than any other, and the relief roll is larger than anywhere else."

In this connection the committee has undertaken to prepare and publish, with the approval and commendation of the State Commissioners of Mental Hygiene and Social Welfare, and the Director of the Temporary Emergency Relief Administration, a report of its study of methods of relief distribution with a view to eliminating undesirable and mentally unhealthful procedures, as the agencies that supply the material needs of the unemployed are in many instances using methods that tend to break down morale rather than to build it up.

Dr. Clarence O. Cheney, Director of the New York State Psychiatric Institute and Hospital, reported on the activities of the subcommittee on mental-hygiene training in schools of nursing. This committee has prepared a syllabus on mental hygiene, which has been approved by the state education department, and which is intended for use in general hospitals that do not have the benefit of the more intensive courses offered in training schools in mental hospitals. The course consists of 30 hours of mental hygiene and psychology, dealing with the understanding and development of normal personality and the prevention of mental disorders, and 15 hours of psychiatric nursing. It will be tried out in training schools this fall.

Miss Katharine G. Ecob, Executive Secretary of the New York State Committee on Mental Hygiene, reported for the subcommittee on legislation, which opposed the enactment of several measures regarded as detrimental to mental-hygiene interests and sponsored others considered desirable, among them a bill providing for the establishment of a list of qualified psychiatrists. Enactment of this measure would raise the whole standard of court procedure in regard to the utilization of psychiatry and would be a help to people in the community in finding competent psychiatrists. It failed of passage, but will be vigorously promoted again at the next session of the legislature.

A résumé of the activities and programs of mental-hygiene societies in other states was presented by Dr. Clarence M. Hincks, General Director of The National Committee for Mental Hygiene, who complimented the New York Committee on its achievements during the past year. Stressing the importance of state-society work, Dr. Hincks said that the "backward" states were mostly those without mental-hygiene societies, and cited as evidence the fact that such states failed, in most instances, to secure money from the funds made available by the Public Works Administration and sorely needed for the expansion of state-hospital facilities. All the societies, he further

reported, have been hampered by lack of funds. There are altogether, he said, 23 state societies for mental hygiene, of which 16 are active and seven inactive. Of local societies there are 19 active and 19 inactive.

In conclusion, Dr. Hincks expressed the wish that the National Committee could establish a division of state societies, with the hope of being able to work out plans for fund raising and unification of programs so that a really national mental-hygiene movement might be developed throughout the country. "I feel," Dr. Hincks said, "that the future of these societies is reasonably bright because of the type of the individuals supporting them. They are the very cream of the community. The eagerness of the professional groups and the public for instruction and light in mental hygiene is also most encouraging."

The outstanding gain for mental hygiene in the city during the past year, according to the last annual report of Miss Suzanne H. Crawford, Executive Secretary of the New York City Committee on Mental Hygiene, was the extension of the services of the Bureau of Child Guidance of the Board of Education in Manhattan to three other boroughs of the city—Queens, Brooklyn, and the Bronx—leaving Richmond the only borough still unprovided for. This committee—of which Dr. George S. Stevenson is chairman and Dr. George K. Pratt medical director—functions as the Section on Mental Hygiene of the Welfare Council, the coördinating agency for social-work organizations in New York City. The committee also assisted the Bureau of Child Guidance in planning an advanced course in individual case studies for teachers who had previously taken courses in mental hygiene. Three series in this course were organized—one in Brooklyn, one in Manhattan, and one in the Bronx—with 175 teachers taking the course.

Next in importance was the committee's study of the professional standards and qualifications of various technical personnel in mental-hygiene and psychiatric clinics throughout the city. A report of this study, considered epoch-making in the development of sound administrative practices in the clinic field and invaluable to all organizations seeking to establish their services on the highest level, will shortly be published.

The committee is also conducting a survey of "border-line" mental-hygiene clinics, which have been growing with uncomfortable rapidity. As many of these are of questionable standing, an effort is being made to determine whether or not some form of licensing should be recommended. A second study, that of mental-hygiene activities in the high schools of New York City, has been undertaken with a view to the appraisal and improvement of the personal coun-

seling and guidance services that have grown up in junior and senior high schools in the past two to three years.

Pennsylvania

The Mental Hygiene Committee of the Public Charities Association of Pennsylvania is continuing its studies of fundamental problems concerning the mentally ill and mentally defective, and of the best methods of meeting the needs of these groups in clinics, hospitals, and training schools, and is actively promoting public support of appropriations for the capital construction and development of these institutions. Establishment of the Western State Psychiatric Hospital, to be erected on a site deeded to the Commonwealth by the University of Pittsburgh, is a major objective. The need for this institution for the treatment of curable mental disorders, for the training of psychiatric personnel, and for intensive research is being stressed, and immediate construction of this hospital is being urged.

Another major activity is the movement to secure complete state care of the mentally sick as against the present unsatisfactory system of county, poor-district, municipal, and state mental hospitals. As an important step in this direction the committee recently carried on an intensive campaign to effect the transfer of the Philadelphia Hospital for Mental Disease at Byberry to the state, for operation as a state mental hospital. The policy of complete state care has been endorsed by the state medical society and has received extensive newspaper publicity and support.

The educational activities of the committee during the past year have been aimed at a wider application of mental-hygiene knowledge by physicians, nurses, social workers, educators, and parents. To this end the committee has worked up outlines for standardized courses for teaching purposes in the fields of medicine, nursing, social work, law, and education, and for the general public. It has also stimulated increased clinical facilities and other psychiatric and mental-hygiene activities in the various communities.

Psychiatric Implications in Education

A novel feature of the American Psychiatric Association's five-day program in Washington was the "Symposium on Education—Psychiatric Implications," in which educational problems at various age levels were discussed by an educator and three psychiatrists who have specialized in child-guidance work.

Dr. Douglas A. Thom, of Boston, opened the symposium with a discussion of the pre-school child, in which he stated that many of the mental breakdowns of later life were due to the fact that many

people were not taught "how to live" and were trying to meet adult situations with infantile equipment. He advocated an early beginning in the educational process of teaching the child how to live by developing habits, personality traits, and behavior patterns that will help him to meet the realities to be faced in later life. The education, training, and experience of early years, he said, played a vital part in the growth and development of the child's psychic life, and determined to a great extent his ability or inability to adjust well in later life.

Asserting that it was "fatal for psychiatrists and teachers to work in isolation," each group "ignorant of those phases of child life with which the other deals," Dr. Vivian T. Thayer, of the Ethical Culture Schools of New York, urged closer coöperation between psychiatrists and educators. "In present-day practice," Dr. Thayer said, "teachers are unaware of aspects of the child's life to which psychiatrists give the greatest weight—namely, the relations to his parents, brothers and sisters, and playmates. It is thus important for the psychiatrist to assist teachers in understanding the nature and significance of these relationships, not merely in order that the school may thereby better understand and govern contacts with the child, but in order that it may organize and select subject matter in the light of these considerations. Similarly, the psychiatrist presumes to treat children without knowing the curriculum in the school from which his patients come. He deals with the child's school environment only superficially and externally, persuading the school to modify its program slightly or to transfer a pupil from one teacher or grade to another or perhaps to add or drop a subject."

Viewing education as a process of change in the individual which implies an acceptance of change by the individual, Dr. Frederick H. Allen, of Philadelphia, discussed the problems met in children in the grades. "There are factors in the educational program, both inherent and superimposed, which stir the resistance of the individual to the taking on of things that are not originally a part of himself," he said.

In the well-organized and healthy educational system, Dr. Allen continued, the constructive and creative forces are stronger than the resistances aroused in the individual, so that he willingly participates in the educational process. It is particularly important that the grade child, in adapting himself to the school, should develop a positive attitude toward learning. Dr. Allen then discussed at some length the forces within the child and in the school system which help or hinder the development of such an attitude by the child.

Dr. George S. Stevenson, of New York, continued the symposium with a discussion of the psychiatric implications of education at the high-school level which was, in a sense, a development of the theme

of the two preceding speakers that the principal objective of the school was in developing the potentialities of the student so that he would be equipped to meet situations in life in a satisfactory manner. In addition, it is sometimes necessary to change the child himself, Dr. Stevenson said. "This is accomplished through curricular and extra-curricular activities as well as by individual service."

Stressing the mutual interests of psychiatry and education, Dr. Stevenson said: "The school is remaking or molding the child in a much more fundamental way than ever before, and in so doing, comes very close to the interests of psychiatry. There is evidence that this molding process is now becoming the primary rather than the secondary job of the school—that the focus of the school seems to be shifting from mere transmission of knowledge and skills to the permanently significant molding process. . . . Psychiatry and education are complementary functions, occupying different ranges of the scale, but necessarily overlapping to a degree. This demands a degree of mutuality of training which at present is practically nonexistent, because the mutuality is not generally appreciated and because of the jealously guarded departmentalization in our universities. These departments are caissons that provide for each group an atmosphere of its own that it tends to preserve."

Dr. Stevenson compared the type of youth entering our high schools to-day with that of fifty years ago, and stated that the most striking change was the democratization of the high school. In 1880, according to Dr. Stevenson, only 2.8 per cent of boys and girls of high-school age were attending high schools. To-day more than 50 per cent attend high school. This means that in the past the group was "more uniform and was selected for high intelligence, high economic level, and high prospects of college, whereas to-day there is a wide range of ability and need."

Stressing the high-school period as one of extreme significance in shaping the child's future life, Dr. Stevenson said: "Here is the age of highest expectancy of mental disease, the tenth grade, where to-day two in every classroom of about forty are prospective mental-hospital patients. Here is the one place where professional observation is sufficiently continuous and informed to capture the prodromata (advance symptoms) of dementia praecox. Attitudes toward reality, emancipation of thought and action, feelings of inferiority, and religious conflicts all come to expression and crisis. . . . The high school once developed to its full capacity presents the best resource for study in the genesis of personality in this second decade."

While Dr. Stevenson viewed the high-school period as the critical one from the standpoint of mental conflict, Dr. Allen regarded the grade-school period as one that shapes the child's subsequent attitude

toward education. He begins to ask, "What practical use is this or that?" "In other words, there is less sensitiveness to educational content and to formal requirements and a greater sensitiveness to individual rights and interests."

Dr. Allen also said that it was a mistake to place too much emphasis on the intellectual aspects of education in the grades. The grade period is the important period in determining later attitudes toward learning, and to emphasize content would "set in motion so much negative strength that children become resistive to intellectual development in later years."

In discussing rigidity of treatment as compared to the withdrawal of direction, Dr. Allen advocated intelligent direction of the child's efforts. "Every child needs authority and direction," he said. The concept of freedom to be himself in the earlier period is psychologically unsound because differentiation has not developed in the child to the point where he has any clear conception of what is his own self. So instead of freedom there may be confusion and fear. Direction tempered by respect for the individuality of the person seems a biological necessity."

Dr. Little Completes Twenty-five Years at Letchworth

A surprise party to celebrate his twenty-fifth anniversary as Superintendent of Letchworth Village was given at that institution on July 2 for Dr. Charles S. Little, "Squash" Little of Dartmouth football days, by a large group of his friends and admirers, headed by Dr. Frederick W. Parsons, Commissioner of Mental Hygiene, who, in addressing the gathering, said in part:

> "Dr. Little is one of the select few who have been privileged to see in his mind's eye a goal embracing a great humanitarian enterprise, and to enjoy its realization. Letchworth Village was the objective. He conceived it, started it, and built it, devoting to that end the forceful output of a vigorous personality."

Judge Mortimer B. Patterson of Nyack, President of the Board of Visitors of Letchworth Village, presented Dr. Little with a case of silver instruments for medical use as a token of affection and admiration from him and his colleagues on the Board of Visitors.

A brief address was made by Franklin B. Kirkbride, a member of the Commission that selected the site of Letchworth Village in 1907, who has also served as a member and Secretary of the Board of Visitors since the institution was established. Mr. Kirkbride said in part:

> "Dr. Little has made Letchworth Village. It is his lifework, his monument. He is the ideal executive. He plans and judges the value of men and women by their ability to get results."

Letters from friends of Dr. Little were read. Governor Herbert H. Lehman wrote:

> "Your splendid service to the state over a quarter of a century is greatly appreciated. Few men are given the opportunity or the responsibility of serving for so long a time in one position. You have served the people of the state well and with rare devotion, and in their behalf I want to thank you and wish you many more years of health, happiness, and contentment."

Homer Folks, Secretary of the State Charities Aid Association, which was instrumental in securing the legislation that provided for the establishment of Letchworth Village, wrote:

> "Dr. Little had a peculiarly difficult job in the creation of Letchworth Village, but his resources of patience, understanding, perseverance, and character measured up to the occasion. It will be a standing evidence of what good planning, a public-spirited board of managers, and the right kind of an executive can do in creating a public institution which has all the virtues traditionally attributed to a voluntary agency, and all the advantages of status, resource, and scope which inhere in a public institution."

Dr. Arthur H. Ruggles, Superintendent of Butler Hospital, Providence, Rhode Island, wrote:

> "Here's to Squash Little! A grand man! Would that the world could produce more like him. He may be a thorn in the flesh of tradition, red tape, and officialdom, but he is a jewel in the crown of humanitarian effort."

Letchworth Village, now one of the largest of the New York State institutions for the feebleminded, was named by the legislature in honor of the late William Pryor Letchworth, of Buffalo. Dr. Little directed the preparation of plans, and under his administration Letchworth Village has been developed and is now nearing completion. The institution has cost about ten million dollars. When the two groups of buildings now under construction are occupied, the Village will provide accommodations for 3,650 feebleminded cases of both sexes and all ages. Governor Herbert H. Lehman and a group of distinguished citizens laid the cornerstone of these eleven buildings on July 14, 1933.

Dr. Orton Chosen Salmon Memorial Lecturer

The Salmon Committee on Psychiatry and Mental Hygiene has selected for the 1936 Salmon Memorial Award, Dr. Samuel T. Orton, of New York, former President of the American Psychiatric Association and of the Association for Research in Nervous and Mental Diseases. As the recipient of this award, he will deliver the Salmon Memorial Lectures next year.

Dr. Orton has practiced his profession for thirty years and has specialized in psychiatry and neuropathology, with special attention to reading and writing difficulties, stuttering, and other speech disorders. He has published numerous scientific papers on various medical subjects, but more recently has concentrated on a study of the causative factors in writing and language disabilities.

Dr. Orton is professor of neurology and neuropathology at the College of Physicians and Surgeons, Columbia University, and neuropathologist at the New York Neurological Institute. He was formerly professor of psychiatry and director of the Psychopathic Hospital of the Iowa State University. He served as clinical director of the Department of Nervous and Mental Diseases of Pennsylvania Hospital, and has held appointments at the Columbus (O.) State Hospital, at Saint Ann Hospital (Anaconda, Mont.), and at Worcester (Mass.) State Hospital. He also served as a teacher at Harvard Medical School and at Clark University, Worcester. He is a member of many scientific societies, and was a member of the editorial board of the *Archives of Neurology and Psychiatry* for more than ten years.

Latest Census Figures

An increase of 12,752 in the number of patients in public and private mental hospitals in the United States during 1933 is reported by the Federal Census Bureau in a summary of its last (decennial) enumeration, published on August 15. Of the 435,571 patients on the books of these institutions on January 1, 1934, 389,500 were resident patients and 46,071 were on parole or otherwise absent. The first admissions to these hospitals during 1933 totaled 94,689, the principal psychoses represented among first admissions being as follows: dementia praecox, 17,789; manic-depressive psychoses, 12,085; psychoses with cerebral arteriosclerosis, 8,773; senile psychoses, 8,052; general paralysis, 7,166; alcoholic psychoses, 4,651. Dementia praecox was the most frequent type of psychosis in each class of public hospitals, while the manic-depressive was the largest for the private hospitals, with dementia praecox second. In state hospitals the second largest group was manic-depressive; in the county and city the second largest was the senile group; and in Veterans' hospitals the second largest was that of general paralysis. The Bureau's statistics cover the mental patients in 170 state hospitals, 16 Veterans' hospitals, 69 county and city hospitals, and 227 private hospitals, making a total of 483 hospitals and covering all hospitals for mental disease in the country except a few small county and private institutions from which reports could not be obtained.

A 96 per cent increase in the number of patients in institutions for mental defect and epilepsy over the previous general census of those classes taken eleven years ago is shown by the latest enumeration of

the Federal Census Bureau announced last June. Of the 106,764 patients on the books on December 31, 1933, 93,150 were resident in the institutions and 13,614 were on parole or otherwise absent. Of the 12,028 first admissions of the two classes during the calendar year 1933, 6,600 were males and 5,428 females. The group classification of first admissions was as follows: mental defectives, 8,832; epileptics, 2,446; both mentally defective and epileptic, 1,476.

"Epilepsy"

In an address before the Medical Social Service Section of New York City's Welfare Council on June 10, Dr. Henry A. Riley, of the Neurological Institute, recommended the discarding of the word "epilepsy," which he said is being applied indiscriminately and with disastrous results to a whole large group of convulsive disorders, only a small number of which have any malignant tendency. Only the discovery of a cure for epilepsy, Dr. Riley said, would confer a greater boon on humanity than the discarding of this term.

Addressing the Welfare Council's institute on encephalitis, birth injury, and epilepsy, Dr. Riley said: "The patient who is told that he has epilepsy and is ignorant of the enormous variability of this group of disorders immediately assigns himself to the worst category and becomes paralyzed in will, ambitions, and performances, with deplorable results to himself, his family, and his future. It is quite believable that many of the constituents of the so-called 'epileptic personality' are but by-products of this emotional shock produced by all the connotations associated with the term rather than by inherent characteristics of the morbid process itself."

The word "epilepsy," Dr. Riley said, has been carrying a message of despair into the ears and minds of countless patients over many centuries. "There is probably no medical diagnosis except cancer which is impregnated with such horror in the minds of the laity," he continued. "The average individual believes that 'epilepsy' is an incurable disease, that it is characterized by an ever-increasing frequency of convulsive episodes, each one more dreadful than its predecessor, uncontrollable by medication or treatment, condemning the sufferer to the prospect of early mental deterioration, perhaps imbecility, and sure to descend upon the individual at the most inopportune time—in public conveyances, in the office, shop, on the street, at the theater or moving-picture house, or in any sort of social gathering. The medical practitioner knows the falsity of many of the facts of this situation, but carelessly assigns this term, not only to the mild and infrequent attacks which are often only a source of annoyance to the patient, but also to the attacks which are merely

symptoms and represent conditions often susceptible of amelioration, if not cure, such as neurosyphilis, brain tumor, and cerebral arteriorsclerosis."

Sex Variants

Homosexuality and other forms of sexual deviation as they appear in various classes of society will receive intensive study by a special research group formed last spring under the chairmanship of Dr. Eugen Kahn, of the Department of Psychiatry of Yale University, and known as the Committee for the Study of Sex Variants. The committee's objectives are to correlate the various scientific interests in this field of study, and to serve as a scientific sponsoring agency for the furtherance of research on sexual variation.

A study of 50 male and 50 female homosexuals of cultured background is already under way. Other projects planned for are a study of homosexuality as it exists among members of the United States Marine Corps, and a study of homosexual practices among adolescent boys in an institution for juvenile delinquency. The approaches to these studies will be from the psychiatric, endocrinological, roentgenological, and hormonal angles.

The committee, which includes representatives from these and other fields, will be interested in any research projects which have a bearing upon the physiological, psychological, psychiatric, or sociological problems of sex variants. Other psychiatrists serving on this body, besides Dr. Kahn, are Dr. Adolf Meyer, Dr. Clarence O. Cheney, Dr. Edward A. Strecker, Dr. Marion Kenworthy, Dr. George W. Henry, and Dr. Harold D. Palmer. All communications should be addressed to the Secretary, Dr. Robert W. Laidlaw, 199 Fort Washington Avenue, New York City.

New Course in Psychoanalysis

An "advanced social workers' seminar" series will be a feature of the program of the New York Psychoanalytic Institute this fall. The courses, which will be conducted by Dr. I. T. Broadwin, will deal with the "psychodynamics of family and social relationships" and will be confined to a discussion of psychoanalytic principles in relation to practical issues in social case-work, the topics to be covered including delinquency manifestations in the child, conscious and unconscious aggressive attitudes, parental conflicts and their manifestations, character types and family patterns of social behavior, and types of therapeutic procedures. No general theoretical lectures will be given, and attendance will be limited to twenty. The seminars will be given on fifteen successive Thursdays, beginning October 3, at

8:15 P.M. (November 28 excepted). The fee for the course is $15.00, payable on registration. Applications should be made to the Executive Director of the Institute at 324 West 86th Street, New York City.

Mentally Disabled World-War Veterans

Overcrowded conditions in state institutions has brought an urgent need for 6,100 more beds for mentally disabled World-War veterans, Watson B. Miller of Washington, National Chairman of the American Legion Rehabilitation Committee, reported at a recent conference of Legion rehabilitation workers and Veterans' Administration officials.

"There are slightly more than 52,630 veterans hospitalized," Mr. Miller said. "Of these, 39,000 are in Veterans' Administration institutions. Of that number 22,000 are neuropsychiatric, 11,500 general, and 5,000 tuberculous."

New Clinic Directory in Preparation

The National Committee for Mental Hygiene has been making its periodical inventory of psychiatric clinics in the United States preparatory to the publication of a fourth edition of its clinic directory. The purpose of the survey is threefold: to inform the public of the location and types of clinic services available for children and adults; to measure growth and trends in child guidance and adult clinical work by a comparison of present and past conditions in this field; and to supply information of value and help to those organizing psychiatric clinic services or otherwise professionally interested in this field of mental hygiene activity.

The survey is nearing completion, and the new list will be published in the January, 1936, issue of this journal.

CURRENT BIBLIOGRAPHY *

Compiled by

FREDERICK W. BROWN

Addams, Jane. Julia Lathrop's service to the state of Illinois. Social service review, 9:191–211, June 1935.

Allen, Clifford. The diagnosis and treatment of the early psychotic and prepsychotic. British journal of medical psychology (London), 15: 140–52, July 10, 1935.

Atkinson, H. S., M.D. The social control of the feebleminded. Social welfare (Toronto), 15:121–23, June 1935.

Baum, Maurice. William James and psychical research. Journal of abnormal and social psychology, 30: 111–18, April-June 1935.

Beach, Lucy E. Beyond hospital gates. Mental welfare (London), 16:49–59, July 1935.

Beck, Samuel J. Problems of further research in the Rorschach test. American journal of orthopsychiatry, 5:100–115, April 1935.

Bender, James F. What the physical education instructor can do for the stuttering student. Journal of health and physical education, 6:16–17, 56–57, June 1935.

Berrien, F. K. A study of objective dream activity in abnormal children. Journal of abnormal and social psychology, 30:84–91, April-June 1935.

Best, Ernest M. The exceptional child as a behavior problem in society. Social welfare (Toronto), 15:117–19, June 1935.

Bluemel, C. S., M.D. A simple conception of dementia praecox. Colorado medicine, 32:540–47, July 1935.

Bond, Earl D., M.D. Management of convalescent children. Pennsylvania medical journal, 38:591–93, May 1935.

Bowman, Karl M., M.D. Progress in psychiatry for 1934. New England journal of medicine, 213:63–66, July 11, 1935.

Bradshaw, Francis. Sex problems of the 'teens. Parents' magazine, 10: 19, 34, 45, August 1935.

Bragman, Louis J., M.D. The language of psychiatry. New York state journal of medicine, 35:668, July 1, 1935.

Bryan, William A., M.D. State hospitals as training centers. Mental hygiene, 19: 405–15, July 1935.

Bryngelson, Bryng. Now we laugh with stutters. Everybody's health, 20:2–3, 10, August 1935.

Burling, Temple, M.D. Integrating psychiatry with the Winnetka (Illinois) public school system. American journal of orthopsychiatry, 5:132–40, April 1935.

Burr, Charles W., M.D. Personality and physiognomy. Dental cosmos, 77:556–60, June 1935.

Cammarata, J. A., M.D. The diagnostic clinic and the general physician. Mental health bulletin (Pennsylvania department of welfare), 13:14–17, July 15, 1935.

Carberry, Mabel A. An attempt to determine the consistency of judgments regarding the adjustment status of children examined by a child guidance clinic. Journal of juvenile research, 19:75–92, April 1935.

Carter, Gladys. The education of the occupational therapy student in the field of psychiatry. Occupational therapy and rehabilitation, 14:269–72, August 1935.

Cason, Hulsey. A case of anterograde amnesia. Journal of abnormal and social psychology, 30:107–10, April-June 1935.

Chipman, N. Genevieve, M.D. The influence of heredity. Medical woman's magazine, 42:193–6, 203, July 1935.

Clegg, J. L. The association of physique and mental condition. Journal of mental science (London), 81:297–316, April 1935.

Conrad, S. J., M.D. The diagnosis of "neurosis." Journal of the Missouri medical association, 32:233–35, June 1935.

Coward, N. Barrie, M.D. The nervous child. Canadian nurse, 31:263–66, June 1935.

Crichton-Miller, H., M.D. Psychotherapeutic clinics in fact and fancy. British medical journal, 1205–1208, June 15, 1935.

* This bibliography is uncritical and does not include articles of a technical or clinical nature.

Crichton-Miller, H., M.D. The stewardship of mental health. Lancet, 228: 1292–95, June 1, 1935.

Davidson, Marion. The relationship of adjustment status of child guidance clinic cases to age, mental capacity and school placement. Journal of juvenile research, 19:160–70, July 1935.

Dayton, Neil A., M.D. Mental deficiency as a state problem in Massachusetts. Mental hygiene news (Wisconsin society for mental hygiene), 1: March-April 1935.

Dearborn, George Van Ness, M.D. Notes on habituation in mental derangement. Journal of abnormal and social psychology, 30:22–42, April-June 1935.

Dershimer, F. W. The prevention of mental disease. Hygeia, 13:598–600, July 1935.

Doll, Edgar A. A genetic scale of social maturity. American journal of orthopsychiatry, 5:180–90, April 1935.

Doll, Edgar A. The Vineland social maturity scale (continued). Training school bulletin, 32:48–55, May 1935.

Doll, Edgar A. The Vineland social maturity scale (concluded). Training school bulletin, 32:68–74, June 1935.

Driscoll, Gertrude Porter. What's behind naughtiness? Parents' magazine, 10:26–27, 54–57, June 1935.

Drought, R. Alice. A new angle on camping. Parents' magazine, 10: 33, 62–63, June 1935.

Dudycha, George J., and Dudycha, Martha M. A case of synesthesia: visual-pain and visual audition. Journal of abnormal and social psychology, 30:57–69, April-June 1935.

Dunbar, H. Flanders, M.D. Mental hygiene and religious teaching. Mental hygiene, 19:353–72, July 1935.

Edgar, Irving I., M.D. Shakespeare's psychopathological knowledge: a study in criticism and interpretation. Journal of abnormal and social psychology, 30: 70–83, April-June 1935.

Eliot, Abigail A. How shall we teach the child good manners? National parent-teacher magazine, 29:31, 37, 40, June, 1935.

Eliot, Abigail A. Learning through failure and success. National parent-teacher magazine, 29:17, 43, July 1935.

Emch, Minna, M.D. Can occupational therapy records be of value to the psychiatrist? Occupational therapy and rehabilitation, 14:273–79, August 1935.

Faegre, Marion L. The child and his questions. National parent-teacher magazine, 29:8–9, August 1935.

Farr, Clifford B., M.D., and Bond, Earl D., M.D. Facial expression in emotional states. Dental cosmos, 77: 550–56, June 1935.

Farnell, Fred J., M.D. Observations on expert testimony. Journal of nervous and mental disease, 81: 649–53, June 1935.

Felt, Lovelle Helton. Preparing for the first day of school. National parent-teacher magazine, 29:15–16, 36, June 1935.

Findley, J. H. Behavior problems. Training school bulletin, 32: 55–60, May 1935.

Findley, J. H. Leisure time program for the mentally deficient (concluded). Training school bulletin, 32:62–67, June 1935.

Gimson, B. L. Intelligence testing. New era in home and school, 16: 148–50, June 1935.

Gordon, J. Berkeley, M.D. Mental health and tuberculosis. Journal of the medical society of New Jersey, 32:372–75, June 1935.

Granniss, Edward R. Mental hygiene as applied to industrial-accident prevention. Mental hygiene, 19:398–404, July 1935.

Greene, James S., M.D. Treatment of the stutter type personality in a medical-social clinic. Journal of the American medical association, 104: 2239–42, June 22, 1935.

Gregory, Menas S., M.D. Psychiatry in general practice, with special reference to therapy. Journal of the American medical association, 105: 175–81, July 20, 1935.

Hall, J. K., M.D. On the meaning of hallucinations. West Virginia medical journal, 31:306–10, July 1935.

Hardcastle, D. Noel. A suggested approach to the problems of neuropsychiatry. Journal of mental science (London), 81:317–31, April 1935.

Harriman, Philip Lawrence. The Rorschach test applied to a group of college students. American journal of orthopsychiatry, 5: 116–20, April 1935.

Harrington, Milton, M.D. The problem of the defective delinquent. Mental hygiene, 19:429–38, July 1935.

Healy, William, M.D. Psychiatry and the juvenile delinquent. American journal of psychiatry, 91:1311–25, May 1935.

Heath, A. E. and Williams, W. E. Leisure and the adult. New era in home and school, 16:163–64, June 1935.

Hinsie, Leland E., M.D. Socialization through occupational therapy. Occupational therapy and rehabilitation, 14:237–52, August 1935.

Hogan, B. W., M.D. Psychology of the sick. United States naval medical bulletin, 33:373–78, July 1935.

Horton, C. B., M.D. Thinking and practice in forensic psychiatry. Mental hygiene, 19:447–48, July 1935.

Ide, Leta Foster. Averting jealousy. Parents' magazine, 10:22, 50–51, July 1935.

Irons, Lucia. A study of social adjustment and incidence of mental disease in six generations of a family. Smith college studies in social work, 5:297–337, June 1935.

Jack, Lois, and Bradbury, Dorothy E. Will your child be a leader? Parents' magazine, 10:17, 32, 57, July 1935.

Jackson, J. Allen, M.D. The diagnostic clinic; an administrator's viewpoint. Mental health bulletin (Pennsylvania department of welfare), 13:17–18, July 15, 1935.

Jameison, Gerald R., M.D. Some psychiatric aspects of physical diseases. New York state journal of medicine, 35:660–68, July 1, 1935.

Jastrow, Joseph. The current chaos in psychology; and the way out via Psyche's design for living. Scientific monthly, 41:97–110, August 1935.

Jefferson, R. A., M.D. Mental hygiene for the handicapped child. The crippled child, 13:68, 71, August 1935.

Johnson, Hiram Kellogg, M.D. The symptom of loss of feelings: a gestalt interpretation. American journal of psychiatry, 91:1311–25, May 1935.

Johnson, Winifred Bent, and Terman, Louis M. Personality characteristics of happily married, unhappily married, and divorced persons. Character and personality, 3:290–311, June 1935.

Jones, Vernon, and Brown, Robert H. Educational tests. Psychological bulletin, 32:473–99, July 1935.

Josey, Charles C. The self in the light of gestalt psychology. Journal of abnormal and social psychology, 30: 47–56, April–June 1935.

Katz, David. Some fundamental laws of the psychology of needs: hunger. Character and personality, 3:312–26, June 1935.

Knapp, Isabel. An evaluation of a workshop as an aid in child guidance treatment. Smith college studies in social work, 5:352–73, June 1935.

Koehler, John P. Why worry? Hygeia, 13:527–29, June 1935.

Kellogg, Grace. When mothers cheat. Parents' magazine, 10:18, 55–57, July 1935.

Laird, Archibald, M.D. Mental deficiency. American journal of diseases of children, 49:1607–15, June 1935.

Lambert, Charles I., M.D. and Gilpin, Florence B. The mental hygiene program in teachers college, Columbia university. Understanding the child, 5:23–25, June 1935.

Leiner, Joshua H. Nervousness: its cause and prevention. Hygeia, 13: 698–700, August 1935.

Levin, Max. The "dream state" as an epileptic aura, with remarks on the occurrence of elaborate mental states at the beginning of epileptic fits. Journal of neurology and psychopathology, 15:289–96, April 1935.

Levine, Maurice. Psychoanalytic comments on community planning. Family, 16:142–45, July 1935.

Lewis, Aubrey, M.D. Neurosis and unemployment. Lancet, 229:293–97, August 10, 1935.

Liss, Edward, M.D. Libidinal fixations as pedagogic determinants. American journal of orthopsychiatry, 5: 126–31, April 1935.

Lott, George M., M.D. The scope of the problem of delinquency and crime and the contributions of psychiatry. Journal of criminal law and criminology, 26:61–73, May 1935.

Lower, Alvida. The mental hygiene of pregnancy. Public health nursing, 27:433–35, August 1935.

Luff, Mary C., M.D., and Garrod, Marjorie. The after-results of psychotherapy in 500 adult cases. British medical journal, 54–59, July 13, 1935.

Lurie, Louis A., M.D. Endocrinology and behavior disorders in children. American journal of orthopsychiatry, 5:141–53, April 1935.

Lurie, Louis A., M.D. The medical approach to the study of behavior disorders of children. American journal of psychiatry, 91:1379–88, May 1935.

Macht, David I. Moses Maimonides, physician and scientist. Scientific monthly, 41:184–87, August 1935.

Mack, Dorothy. Psychological and emotional values in C.W.A. assignments: a study of sixty-one families on relief before and after C.W.A. Social service review, 9:256–68, June 1935.

Mackay, Fred H., M.D., and Legrand, Emile, M.D. Jean Martin Charcot. Archives of neurology and psychiatry, 34:390–400, August 1935.

Mackenzie, Murdo, M.D. Jung's contribution to clinical psychiatry. Proceedings of the royal society of medicine, section of psychiatry (London), 28:23–36, June 1935.

Maller, J. B. Character and personality tests. Psychological bulletin, 32:500–52, July 1935.

Malzberg, Benjamin. A statistical study of age in relation to mental disease. Mental hygiene, 19:449–76, July 1935.

Marum, Olga. The psychology of the crippled child. Mother and child (London), 6:87–88, June 1935.

McCartney, J. L., M.D., and Papurt, M. J., M.D. Preliminary report on an objective personal data questionnaire. Journal of abnormal and social psychology, 30:95–106, April–June 1935.

Mendeloff, M. I., M.D. The management of the psychoneurotic by the general practitioner. West Virginia medical journal, 31:293–6, July 1935.

Morgan, Christiana D., and Murray, Henry A., M.D. A method for investigating fantasies: the thematic apperception test. Archives of neurology and psychiatry, 34:289–303, August 1935.

National conference on maternity and child welfare—July 1st to 3rd, 1935. Official report. Mother and child (London), 6:165–216, August 1935. Contents includes:

1. The physical and mental welfare of the pre-school child. Paper by G. F. McCleary, M.D.

2. The mental health of the pre-school child. Papers: "Play as an aid to mental health in infant welfare centers" by Clara Stewart.

"The contribution of the nursery school to the mental health of childhood" by Olive Wheeler.

"The work of child guidance clinics for children under five" by William Moodie, M.D.

Nielka, Marguerite. Speech difficulties in childhood. British journal of medical psychology (London), 15: 127–39, July 10, 1935.

Noyes, Arthur P., M.D. Psychotherapy in state hospitals. American journal of psychiatry, 91:1363–66, May 1935.

Oettinger, Katherine Brownelle. When illness comes. National parent-teacher magazine, 29:17, 40, August 1935.

Olson, Elma. Mental health needs of the adolescent. Mental health bulletin (Illinois society for mental hygiene), 13:1–2, June 1935.

Orgel, Samuel Z., M.D. Etiological factors in the production of neuroses and their treatment. Archives of pediatrics, 52:325–34, May 1935.

Ormsby, M. E. Hobby horses. Occupational therapy and rehabilitation, 14:253–67, August 1935.

Osgood, C. W., M.D. Mental changes associated with pernicious anemia. Journal of the American medical association, 104:2155–57, June 15, 1935.

Patry, Frederick L., M.D. Planning a state wide school health program. Medical record, 142:22–24, July 3, 1935.

Patry, Frederick L., M.D. To eat or not to eat. Hygiea, 13:592–93, July 1935.

Patry, Frederick L., M.D. What college student should know about present-day mental hygiene. Journal of abnormal and social psychology, 30: 4–16, April–June 1935.

Peck, Martin W., M.D. A psychiatrist views the drama. Psychoanalytic review, 22:306–13, July 1935.

Perkins, T. J., M.D. The importance of mental hygiene to the general practitioner. New Orleans medical and surgical journal, 88:16–19, July 1935.

Pilpel, Cecile. When our children marry. Parents' magazine, 10:20–21, 81–82, June 1935.

Pintner, Rudolf. Intelligence tests. Psychological bulletin, 32:453–72, July 1935.

Pitfield, Robert L., M.D. Chaucer's nervous depression. Journal of nervous and mental disease, 82:30–32, July 1935.

Popenoe, Paul, M.D., and Ryan, John A. A debate on sterilization. Forum, 94:26–31, July 1935.

Proceedings of the first conference of coördinating councils of California. Journal of juvenile research, 19:93–113, April 1935.

Contents:

1. The beginning of coördinating councils, by Virgil E. Dickson.

2. Purposes and accomplishments of the coördinating councils, by Norman Fenton.

3. The future program of coördinating councils, by K. S. Beam.

Prophylactic mental hygiene. Journal of neurology and psychopathology, 15:336–38, April 1935.

Randall, Edward, M.D., and Wilson, Lucius R., M.D. Solving a difficult problem for the psychiatric department. Modern hospital, 44:56–58, June 1935.

Report of committee of clinical section of American psychological association. Psychological clinic, 23:2–140, January–June 1935.

Contents:

1. The definition of clinical psychology and standards of training for clinical psychologists.

2. Guide to psychological clinics in the United States.

Report on a series of debates held under the auspices of the national council for mental hygiene at Manson house, 26 Portland Place. London, W. 1. Mental hygiene (London), 14:77–109, July 1935.

Contents:

1. That voluntary sterilization should be legalized, by C. P. Blacker and Halliday Sutherland.

2. That theft is frequently a symptom of disease, by Edward Glover and J. Platts-Mills.

3. That competition is a help to mental health, by H. Crichton-Miller and R. E. Roper.

4. That psychological factors play an important part in the causation of war, by William Brown and C. H. Douglas.

Research in psychiatry. Lancet, 228: 1223–24, May 25, 1935.

Rhoades, Winfred. Group training in thought control for relieving nervous disorders. Mental hygiene, 19:372–86, July 1935.

Ricciardi, Patricia. Summarizing the parent interview in a child guidance clinic. Journal of juvenile research, 19:146–59, July 1935.

Ridenour, Nina. The treatment of reading disability. Mental hygiene, 19:387–97, July 1935.

Rogers, Mary M. Unmarried parents: nurses and social workers discuss a common problem. Public health nursing, 27:416–20, August 1935.

Rowe, Allan Winter. Some recent trends in scientific medicine. Medical record, 142:57–62, July 17, 1935.

Rozenzweig, Saul, M.D. Outline of a coöperative project for validating the Rorschach test. American journal of orthopsychiatry, 5:121–23, April 1935.

Sandy, William C., M.D. Community activities for mental health. Mental hygiene news (Wisconsin society for mental hygiene), 1:March–April 1935.

Schilder, Paul, M.D. Psychoanalysis and philosophy. Psychoanalytic review, 22:274–87, July 1935.

Schilder, Paul, M.D. Reaction types resembling functional psychosis in childhood on the basis of an organic inferiority of the brain. Mental hygiene, 19:439–45, July 1935.

Schroeder, Theodore. What is a psychologic recovery? Psychoanalytic review, 22:258–73, July 1935.

Schultz, Gladys D. Must parents worry about thumb-sucking? Parents' magazine, 10:20, 43–44, July 1935.

Scotford, John R. Don't preach—suggest. Parents' magazine, 10:15, 61, August 1935.

Scully, Francis J. The nervous child. Hygeia, 13:622–24, July 1935.

Seiler, Elizabeth S., M.D. Emotional-social life-endocrine reaction. Medical woman's journal, 42:186–88, July 1935.

Singer, H. Douglas, M.D. Research in psychiatry. Journal of the American medical association, 104:2223–26, June 22, 1935.

Smith, Philip, M.D. Food service in institutions of the New York state department of mental hygiene. American journal of psychiatry, 91: 1367–77, May 1935.

Some encouraging statistics. Monthly bulletin (Massachusetts society for mental hygiene), 14: May–June 1935.

Stern, William. On the nature and structure of character. Character and personality, 3:270–89, June 1935.

Stevenson, George S., M.D. Orthopsychiatry—an expression of a philosophy of function. American journal of orthopsychiatry, 5:87–99, April 1935.

Stolinsky, Aaron, M.D. Psychoanalysis: a brief résumé of its meaning and methods. Journal-lancet, 55: 315–20, May 15, 1935.

Stone, Simon, M.D. What mental hygiene means to a community. Mental hygiene, 19:416–28, July 1935.

Stulliken, Edward H. How the Montefiore school prevents crime. Journal of criminal law and criminology, 26: 228–34, July 1935.

Sullivan, Elizabeth Ann, M.D. The rôle of psychological maladjustment in college and in later placement. Journal of nervous and mental disease, 82:147–61, August 1935.

Tate, Mildred. The influence of the depression on the intake of feeble-minded children at the institute for juvenile research. Smith college studies in social work, 5:338–51, June 1935.

The third European reunion of mental hygiene. Lancet, 229:340–41, August 10, 1935.

Thurow, Mildred B. Succeeding as a family. Parents' magazine, 10:24–25, 59–62, June 1935.

Troyanovsky, Alexander A. Progress in medical training and research in the U.S.S.R. Science, 82:137–42, August 16, 1935.

Uchimura, Y., M.D. "Imu," a malady of the Ainu. Lancet, 228:1272–73, June 1, 1935.

Weill, Blanche. Building self-confidence. Parents' magazine, 10:30, 52, June 1935.

Weiss, Anni B. Qualitative intelligence testing as a means of a diagnosis in the examination of psychopathic children. American journal of orthopsychiatry, 5:154–79, April 1935.

White, William A., M.D., and Sanger, Monie. Modern housing of mental patients. Modern hospital, 45:42–47, July 1935.

Wile, Ira S., M.D. Emotional behavior during early childhood. Medical record, 142:24–27, July 3, 1935.

Winslow, C.-E.A., M.D. A community mental hygiene program—the next great opportunity. Milbank memorial fund quarterly (New York), 13:211–18, July 1935.

Wolfe, W. Beran, M.D. The psychopathology of the juvenile delinquent. Medical record, 142:19–22, July 3, 1935.

Woods, Andrew H., M.D. Successful living. Iowa public health bulletin, 49:3–16, April, May, June 1935.

Young, Erle Fiske. The coördinating council plan in Los Angeles county. Journal of criminal law and criminology, 26:34–40, May 1935.

Zilboorg, Gregory, M.D. Some physical aspects of mental disease. New York state journal of medicine, 35:705–13, July 15, 1935.

INDEX TO VOLUME XIX

INDEX TO AUTHOR AND TITLE

BOOK REVIEWS

LISTED BY AUTHORS OF BOOKS